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S. HRG. 101-672, PT. 3

INVESTIGATION OF SENATOR DAVID F. DURENBERGER

EXHIBITS

BEFORE THE

SELECT COMMITTEE ON ETHICS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

SPECIAL COUNSEL HEARING EXHIBITS

PART 3 OF 7
CONTAINS VOLUMES 7 THROUGH 12

JUNE 12-13, 1990

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VOLUME VII

EXHIBITS 157–179

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

SPRINGFIELD, MASSACHUSETTS 01111 / (413) 788-8411

Barry Gottehrer
Senior Vice President

January 17, 1985

Dear David:

Pat and I were both sorry that you weren't able to make the trip to Phoenix. Just in case she hasn't told you, Penny and Pat cleaned up again! Perhaps we can save ourselves some money by jointly buying two trophy cases.

While we were there, I asked Penny if you were taking any speaking engagements -- because I had one in mind that I think would be of interest to you. The engagement I am referring to is our annual Group Life and Health Conference slated for May 19-22 at the Marco Beach Hotel, Marco Island, Florida. Penny thought you might be interested in our conference because it would give you the opportunity to address our President and Chief Executive Officer, Bill Clark, the Executive Vice President and head of our Group Life and Health Division, Sy Sternberg, and approximately 100 of our Group Life and Health representatives and home office executives and their spouses -- obviously, of course, if your schedule permitted.

When I spoke to Mike Murray about the event this past Monday, he called Anne Kelly and she suggested that I send a letter to you immediately.

I would love to have you and Penny as our guests for all or part of the entire conference depending upon your schedule. However, since your time is precious, we would like to have you speak on any one of these days for about 20 minutes on tax and health care issues and then be available to answer questions. We would, obviously, pay transportation and all other expenses for both of you plus the maximum speaking fee.

SPECIAL
COUNSEL
HEARING
EX. 157

A

BARRY GOTTEHRER
APR 8 P.M.
SENIOR VICE PRESIDENT
PUBLIC AFFAIRS

LIAM
LIFE INSURANCE ASSOCIATION OF MASSACHUSETTS
OLD CITY HALL
45 SCHOOL ST.
3RD FLOOR
BOSTON, MA 02108
TELEPHONE: 617-742-4250

BARRY GOTTEHRER
APR 8 P.M.
SENIOR VICE PRESIDENT
PUBLIC AFFAIRS

April 4, 1985

TO: Barry Gottehrer
Seymour Sternberg

From: Steven Tringale

RE: Senator D. Durenberger

In anticipation of your upcoming Florida meeting with Senator Durenberger, I have compiled two recently published articles by the Senator. In addition, this memo will outline my understanding of Senator Durenberger's health care philosophy based on a series of meetings I have had with the Senator and his staff over the last eighteen months.

First, and foremost, David Durenberger is the leading proponent of a market orientated, free enterprise based health delivery system. The Twin Cities area of Minnesota is one of the highest HMO penetrations in the country. Also, two of the nations leading free market oriented academics in the health policy field, Alan Enthoven and Paul Elwood, have roots in Minnesota. It is obvious that the Minnesota health care experience has strongly influenced Senator Durenberger.

B

• AM LIFE INSURANCE CO. • BERKSHIRE LIFE INSURANCE CO. • BOSTON MUTUAL LIFE INSURANCE CO. • JOHN HANCOCK MUTUAL LIFE INSURANCE CO. • LIBERTY LIFE ASSURANCE CO. OF BOSTON
• LIFE OF AMERICA INSURANCE CORP. OF BOSTON • MASSACHUSETTS INDEMNITY AND LIFE INSURANCE CO. • MASSACHUSETTS MUTUAL LIFE INSURANCE CO. • MONARCH LIFE INSURANCE CO. • NEW ENGLAND MUTUAL LIFE INSURANCE CO. • PATRIOT GENERAL LIFE INSURANCE CO. • PAUL REVERE LIFE INSURANCE CO. • STATE MUTUAL LIFE ASSURANCE CO. OF AMERICA • UNITED EDUCATORS LIFE OF FRAMINGHAM

However, as Chairman of the Health Subcommittee of Senate Finance, Senator Durenberger has displayed a strong sense of the pragmatic. He has protected the Medicare Trust Fund by prodding the Congress and the Administration to institute the national Prospective Payment System (PPS), based on a Diagnostic Related Group (DRG) per case payment system. Since October 1, 1982, when medicare went onto PPS, an inherently regulatory system in the first place, Senator Durenberger has supported a number of arbitrary reductions to Medicare's payment rates based solely on federal budget considerations. Currently, the Senator is focusing on the cost of graduate medical education. He is viewed as the expert on this issue in congress, and has filed a bill which would immediately reduce Medicare's recognition of the "indirect teaching adjustment" from 11.58% to 9.00%, and eventually phase this component out. Massachusetts, because of its huge teaching presence, has attracted Senator Durenberger's attention. He has met up here a number of times with both the Health Care Coalition and the Boston teaching hospitals. I believe the Senator currently favors pulling teaching costs out of the per case payments, and funding medical education in a block grant format.

Senator Durenberger has publicly opposed the all-payer concept that is central to the Medicare waivered states cost containment programs. He believes Massachusetts, New York, New Jersey, and Maryland are inherently anti-competitive and unnecessarily expensive. Again the Senator's private opinions differ considerably to the public rhetoric. While he is skeptical of the waivered states, he is willing to listen. The arguments that have seemed to persuade him that the Massachusetts experiment is not a bad idea are as follows. Any all-payer system must promote and enhance competition at the market level, while maintaining and achieving some basic statewide health policy goals. Massachusetts has accomplished this by allowing selective contracting for PPO's and HMO's (cite Mass. Mutual experience), within an overall gross revenue cap. In other words, Massachusetts does not guarantee net revenue levels to hospitals, but does maintain some system wide cost control. An example of a state wide policy goal is the establishment of state wide funding mechanisms for bad debt and charity care (Sec. 51, C. 372), which has maintained a superior level of access to hospital care for all Massachusetts residents. Senator Durenberger has acknowledged that funding indigent care is one of the major challenges facing Congress in the next iteration of health payment and financing reform.

The Senator has also been moved by the argument that Massachusetts is a very competitive state, (see attached). Also, he has acknowledged that the "state's rights" issue has some merit.

C

This argument is very compelling when you note that the Senator has stated that PPS is not a long term solution to the solvency of the Medicare trust fund. Lastly, Senator Durenberger may raise the issue of Medicare vouchers with your people. On January 18, 1985, the Federal Register published regulation that outlined the requirements for HMO's and Competitive Medical Plans (CMP's) to enroll Medicare subscribers. The Massachusetts Mutual PPO's could conceivably be termed a CMP, and the Senator may ask whether you would be interested in enrolling elderly in your program. (Personal opinion, at least in the short term, enrolling Medicare subscribers under the current regulations, is a win/win proposition. Medicare and the elderly save money, and the plan makes money, if there is any true management of the providers.

If you have any further questions, please give me a call. I believe you can sell the Massachusetts experiment as a competition enhancing, cost saving evolutionary step toward a more market driven health delivery and financing system. This allows you to support the Senator's more general pronouncements regarding competition and an eventual level playing field in the health care system.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY SPRINGFIELD, MASSACHUSETTS 01111

APR 8 19

TO L. Dunreith Kelly
Legislative Research Assistant

FROM William J. Burton
Senior Vice President

M/P B092

M/P J256 EXT. 2293

RE Guest Speaker: Senator David F. Durenberger

DATE April 5, 1985

Thank you for your memo dated April 2nd referencing the above captioned subject.

The program for Sunday night, May 19th, is as follows. We will be recognizing our first time attendees, special guests, and will honor several retirees as well. Therefore, we will be eliminating the small, private dinner. It is hoped that the Senator and his party will be able to join us for these festivities Sunday evening.

I would plan special seating arrangements for the Senator including at the very least, President Clark, Barry Gottehrer, and the Senator.

I have attached a copy of our agenda for Monday, May 20th. The Senator will be introduced by our Chairperson of the Day, Robert F. Moran, CLU. The introductory remarks that you would like us to make should be coordinated with Joe Jennings at:

Joseph T. Jennings
Executive Vice President - Production
Jay J. Sheridan LTD
155 N. Harbor Drive
Concourse Level
Chicago, IL 60601-7384
(312) 565-0002

It is our intention to have the Senator address our entire group which consists of 70 group representatives and their spouses and 20 Home Office executives and their spouses. This will be in the main ballroom which will be equipped with a stage and a podium.

We will not have the finished program available for another two weeks. I would suggest you forward a copy of the final program to him as soon as it is available. Perhaps Anne Clifford can provide you with some general information concerning the hotel and the facilities at Marco Beach Resort.

WJB:po
Attachment

cc: Joseph T. Jennings
Eva Dion
Marketing Services
Group L&H Sales Department
Management Communications

M352 477

ANNE M. PATTERSON

April 9, 1985

Miss Anne C. Kelly
Office of Senator Durenberger
154 Russell Building
Washington, D.C. 20510

Dear ACK:

I do hate to bother you by phone; I know you are ever so busy. So I will opt to bug you in a letter.

Massachusetts Mutual has cut a deal with Piranha Press to purchase 100 copies of NMNM instead of setting up a little stand for the Senator. Piranha-ha will be sending the books to your office for the Senator to "Dave" and date (5-20-85). In a few days I will have the address where the books should be sent in Florida. I should be the one to send them out so you won't have to worry about it at all. You can just let me know when they are all "Daved" and ready to go. (Actually, if the Senator wants, I am still pretty professional at the "Dave" and could take care of the whole thing!!!)

I am still holding on the flight arrangements for both Mike and the Senator until I hear from you. Of course, there is still plenty of time.

The dinner the evening of the 19th (Sunday) is going to be an intimate affair of about five of the big dogs from the insurance peeps, and Mike. When I get all of the names and vital statistics I will get them to you.

Otherwise, my life is going pretty well. Am hoping that your's is spiffy and you are remembering just how special you are to many people. I miss you.

Best,

Anne

.. DION
.CTOR OF COMMUNITY AFFAIRS
D GC.'ERNMENT RESEARCH

MASSACHUSETTS MUTUAL LIFE INS INCE COMPANY
[illegible] Massachusetts / organized 1851
MAY 21 P.M.

OK to pay per B6

Barry:

As you can see from the attached, [redacted] royalties on Durenberger's book are not considered by a consortium and therefore are not limited to $2000.

Please return this document for our file. Ok 5/21

11B

Executive V.P. [illegible] and General Counsel

MAY 20 1985

[illegible] Department

CURTIN, MAHONEY & CAIRNS
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

RICHARD T. CURTIN
MICHAEL C. MAHONEY
JOHN A. CAIRNS
SUSAN L. NEUMEYER
DOUGLAS J. CARNEY
DONNA E. RAMBERY
DEANNE M. GRECO
EDWARD C. ANDERSON
MICHAEL W. SIBLEY
JEFFREY C. ROBBINS
KENNETH COREY-EDSTROM
DAVID J. STEINGART

4500 MULTIFOODS TOWER
MINNEAPOLIS CITY CENTER
MINNEAPOLIS, MINNESOTA 55402
TELEPHONE (612) 333-6441
TELECOPIER (612) 339 6962
TELEX 290161

1800 M STREET N. W.
SUITE 480
WASHINGTON, D.C. 20036
TELEPHONE (202) 887-0710
TELECOPIER (202) 833-8344
TELEX 64 566

OF COUNSEL
ALVIN H. GANDAL
ADMITTED IN D.C. AND OHIO

REPLY TO
Minneapolis

May 16, 1985

Mr. Warren Wise
V. P. and Associate General Counsel
Massachusetts Mutual Life
1295 State Street
Springfield, MA 01111

SENATOR DAVID F. DURENBERGER--SPEAKING ENGAGEMENTS
OUR FILE NO. 01468-007B

Dear Mr. Wise:

Pursuant to your request, enclosed please find a copy of the Advisory Opinion we received from the Federal Election Commission on December 6, 1984. This is delivered to you with the understanding that the nature of the opinion will be kept confidential and no copies will be given to anyone.

If you have any questions regarding this matter, please contact the undersigned.

Very truly yours,

Michael C. Mahoney

MICHAEL C. MAHONEY

Enclosure

SKA0516851

FEDERAL ELECTION COMMISSION
WASHINGTON D.C. 20463

RECEIVED
CURTIN, MAHONEY & CAIRNS
A PROFESSIONAL ASSOCIATION

December 6, 1984

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

ADVISORY OPINION 1984-56

Michael C. Mahoney
Donna E. Hanbery
Curtin, Mahoney & Cairns
Attorneys at Law
4150 Multifoods Tower
Minneapolis City Center
Minneapolis, Minnesota 55402

Dear Mr. Mahoney and Ms. Hanbery:

This responds to your letter of October 19, 1984, requesting an advisory opinion on behalf of Senator David Durenberger concerning application of the Federal Election Campaign Act of 1971, as amended ("the Act"), to an author-publisher agreement involving Senator Durenberger.

You state that Senator Durenberger has written a book entitled Neither Madmen nor Messiahs. You add that the book is published by Piranah Press, a division of Diamond Publications ("Publisher"), and will be distributed by the Publisher through traditional and customary channels of distribution.

According to your request, under the author-publisher agreement Senator Durenberger has conveyed to the Publisher certain rights in the book and has also agreed to make a specified number of promotional appearances over a two-year period to promote both the book and the Publisher. As compensation for the rights in the book transferred by Senator Durenberger and for the personal services to be rendered by him to promote the book and the Publisher, the Senator will be paid an agreed-to sum in quarterly installments over a two-year period as well as a royalty based on the net proceeds from sales of the book. In light of these facts, you ask whether any of the income

to be received by Senator Durenberger from the Publisher would constitute honoraria under the Act or Commission regulations.

Under 2 U.S.C. §441i, no person who is an elected or appointed officer or employee of any branch of the Federal Government shall accept any honorarium of more than $2,000. The Commission's regulations define the term "honorarium" to mean the payment of money or anything of value received by such person as consideration for an appearance, speech, or article. 11 CFR 110.12(b). The Commission has previously determined that income realized from the publication of books is not considered honoraria, and therefore is not subject to the limitations of 2 U.S.C. §441i. See Advisory Opinions 1975-77 and 1978-59. Accordingly, any royalty paid to Senator Durenberger on the basis of the net proceeds from sales of the book would not be considered an honorarium under the Act and regulations and would not be limited.

The Commission also notes that the regulations exclude from the definition of honorarium the term "stipend." A stipend is defined as a payment for services on a continuing basis. 11 CFR 110.12(c)(3). The Commission concludes that the arrangement you have described, whereby the Publisher will pay Senator Durenberger in quarterly installments over a two-year period for promotional appearances, creates a stipendiary relationship. Accordingly, payments made to Senator Durenberger under this agreement would not be viewed as honoraria and therefore would not be subject to limitation under 2 U.S.C. §441i.

The Commission expresses no opinion as to possible application of Senate rules to the described transaction, nor as to any tax ramifications, since those issues are outside its jurisdiction.

This response constitutes an advisory opinion concerning application of the Act, or regulations prescribed by the Commission, to the specific transaction or activity set forth in your request. 2 U.S.C. §437f.

Sincerely yours,

Lee Ann Elliott

Lee Ann Elliott
Chairman for the
Federal Election Commission

Enclosures (AOs 1975-77 and 1978-59)

7604107214

ADVISORY OPINION 1975-77

Whether Royalties Are Subject
to Limitations on Acceptance
of Excessive Honorariums

This advisory opinion is rendered under 2 U.S.C. §437f in response to a request for an advisory opinion which was submitted by J. Brian Smith, Press Secretary, for Congressman John J. Rhodes, which was published as AOR 1975-77 in the October 1, 1975, Federal Register (40 FR 45295). Interested parties were given an opportunity to submit written comments relating to the request. No comments were received.

The request asks whether royalties from the publication of a book by a Congressman would be limited by the provisions of section 616 of Title 18, United States Code. It is provided in 18 U.S.C. §616 that:

> "Whoever, while an elected or appointed officer or employee of any branch of the Federal Government--
>
> (1) accepts any honorarium of more than $1,000 * * * for any appearance, speech, or article; or
>
> (2) accepts honorariums * * * aggregating more than $15,000 in any calendar year; shall be fined not less than $1,000 nor more than $5,000."

This provision clearly limits honoraria accepted for any appearance, speech, or article. The question then arises as to whether, for purposes of this section, a royalty received

for the publication of a book should be treated as identical to an honorarium accepted for an article. As 18 U.S.C. §616 is a criminal statute, the canons of statutory construction require that its language should be strictly construed so that each word will be given only its plain meaning in the absence of strong evidence to the contrary. Thus in this case the Commission concludes that the word "article" should be read narrowly and not interpreted as meaning "any publication."

This view conforms with the explicit intent of Congress with regard to this section:

> "Mr. HUGH SCOTT. * * * I have been asked by one Senator to raise a question as regards publication of books as distinguished from magazine articles. There is a limitation here on honoraria of $1,000. I believe there is an exception that does permit Members of Congress to publish books and to receive compensation for that purpose. Is that correct?
>
> "Mr. CANNON. The intent is that the publishing of a book does not constitute an honorarium under the language used in the bill. * * *"
>
> 120 Cong. Rec. S18526(daily ed., Oct. 8, 1974)
>
> "Mr. FRENZEL. [Presenting comments for the House of Representatives on the Conference Report.] * * * The conference substitute limits honorariums to $1,000 per appearance and a total of $15,000 per calender year. I concur with the discussion by Senators Scott and Cannon * * *."
>
> 120 Cong. Rec. E10334 (daily ed., Oct. 10, 1974)

7604107715

Accordingly, it is the opinion of the Commission that royalties from the publication of a book by a Congressman would not be affected by the provisions of 18 U.S.C. §616.

This advisory opinion is issued only on an interim basis pending the promulgation by the Commission of rules and regulations of general applicability.

Date: Oct. 30, 1975

Thomas B. Curtis
Chairman for the
Federal Election Commission

7604100716

September 20, 1978

AO 1978-59

Honorable Daniel Patrick Moynihan
United States Senate
Washington, D.C. 20510

Dear Senator Moynihan:

This is in response to your letter of July 31, 1978, requesting an advisory opinion on the application of the Federal Election Campaign Act of 1971, as amended ("the Act"), to your receipt of income in connection with the republication of material you wrote some time ago which has now been, or will be, reprinted.

Your letter states that on several occasions you have received requests and have consented to the reprinting of your previously published writings. You add that these requests come from other authors or publishers and are usually "accompanied by a modest fee." Three examples are set forth in your letter:

> A fee from Readers Digest for reprinting an article originally published in 1977 in Commentary;
>
> A fee from Harper and Row for reprinting an article published in 1969 in American Heritage Magazine;
>
> Fees from college text publishers for excerpts from various books published over the past 15 years.

You ask for a Commission opinion clarifying whether these payments would be considered "honoraria" under the Act and Commission regulations. Your letter explains

that "no additional work" is required of you in connection with the reprinting and that these payments "most often accrue to me for my copyrights. As such, they are, in effect, royalties. (Or, if you like, rents.)"

As you know, the Act limits the amount of any honorarium that elected or appointed officers of the Federal Government may accept for any "article" (as well as for any "appearance [or] speech") and for any calendar year. 2 U.S.C. §441i (as amended by Public Law 95-216, December 20, 1977). While §441i does not include definitions for "honorarium" or "article," Commission regulations do define those terms as well as others used in §441i.[1/] The term "honorarium" means a payment of money or anything of value received by an officer or employee of the Federal Government, if it is accepted as consideration for an appearance, speech, or article. 11 CFR 110.12(b). An "article" means a writing other than a book which "has been or is intended to be published." Income realized from the publication of books is not considered "honoraria;" hence, it is not subject to the limitations of 2 U.S.C. §441i. See Advisory Opinion 1975-77, copy enclosed.

The Commission concludes that payments received as consideration for the reprinting of an article are not excluded from the definition of "honorarium". It is clear that the article is generating income by reason of its reprinting or republication regardless of how that income may be characterized for purposes other than §441i. Whether or not additional effort is required from the author to produce the income from the reprint is irrelevant. The Act and regulations place limits on payments accepted for the publication of any article which "has been or is intended to be published." 11 CFR 110.12(b)(4). Thus, every occasion of publication or republication of an article, other than in a book, by an officeholder which results in payments to the officeholder is an honorarium.

Accordingly, in your specific situations, to the extent payments are accepted and received by you while you are a United States Senator (or other elected or appointed officer or employee of the Federal Government) as consideration for the current reprinting or republication as an article of works you previously wrote (whether the work was originally

1/ The 1977 amendments to 2 U.S.C. §441i have effectively superseded the regulatory definition of "accepted" at 11 CFR 110.12 (b)(5), but that definition is immaterial to this opinion.

published as an article or book), those payments are honoraria for articles. However, payments resulting from the current republication or reprinting in a book of material originally published in either book or article form, will be treated as income from the publication of a book and thus will not be subject to limitation under §441i as an honorarium. See AO 1975-77.

The Commission expresses no opinion as to possible application of the Senate rules to the described transactions, nor as to any tax ramifications, since those issues are outside its jurisdiction.

This response constitutes an advisory opinion concerning the application of a general rule of law stated in the Act, or prescribed as a Commission regulation, to the specific factual situation set forth in your request. See 2 U.S.C. §437f.

Sincerely yours,

/s/

Joan D. Aikens
Chairman for the
Federal Election Commission

Enclosures(AO 1975-77)

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

SPRINGFIELD, MASSACHUSETTS 01111 / (413) 788-8411

April 22, 1985

Mr. Gary L. Diamond
Piranha Press
4504 Excelsior Boulevard
Minneapolis, MN 55416

Dear Mr. Diamond:

Per our agreement, enclosed is a check for $450 for 100 copies of "Neither Madmen Nor Messiahs" to be shipped to Senator Durenberger at his Washington office for autographing. Annie Patterson will then ship the books to the Florida address where the conference is to be held.

Sincerely,

Barry Gottehrer

Mr. Barry Gottehrer
Senior Vice President

JAB/hs

cc: Mr. Murray

Enc.

[redacted]

P0193

TO: COMPTROLLER'S DEPT – E100 **EXPENSE PAYMENT REQUEST**

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE As soon as possible

ENCLOSURE YES NO

PAYABLE TO Piranha Press

ADDRESS 4104 Excelsior Boulevard
Minneapolis, MN 55416

AMOUNT $ 450.00

COMPLETE CHARGE ACCOUNT CODE			AMOUNT
MAJOR CODE	SUB-CODE	COST CENTER	
367	202	700	$450.00

Enter exactly what is to appear on check

100 copies of "Winter Haiku per Haiku"

Total charges must equal check amount

$450.00

ACCT. STRUCTURE

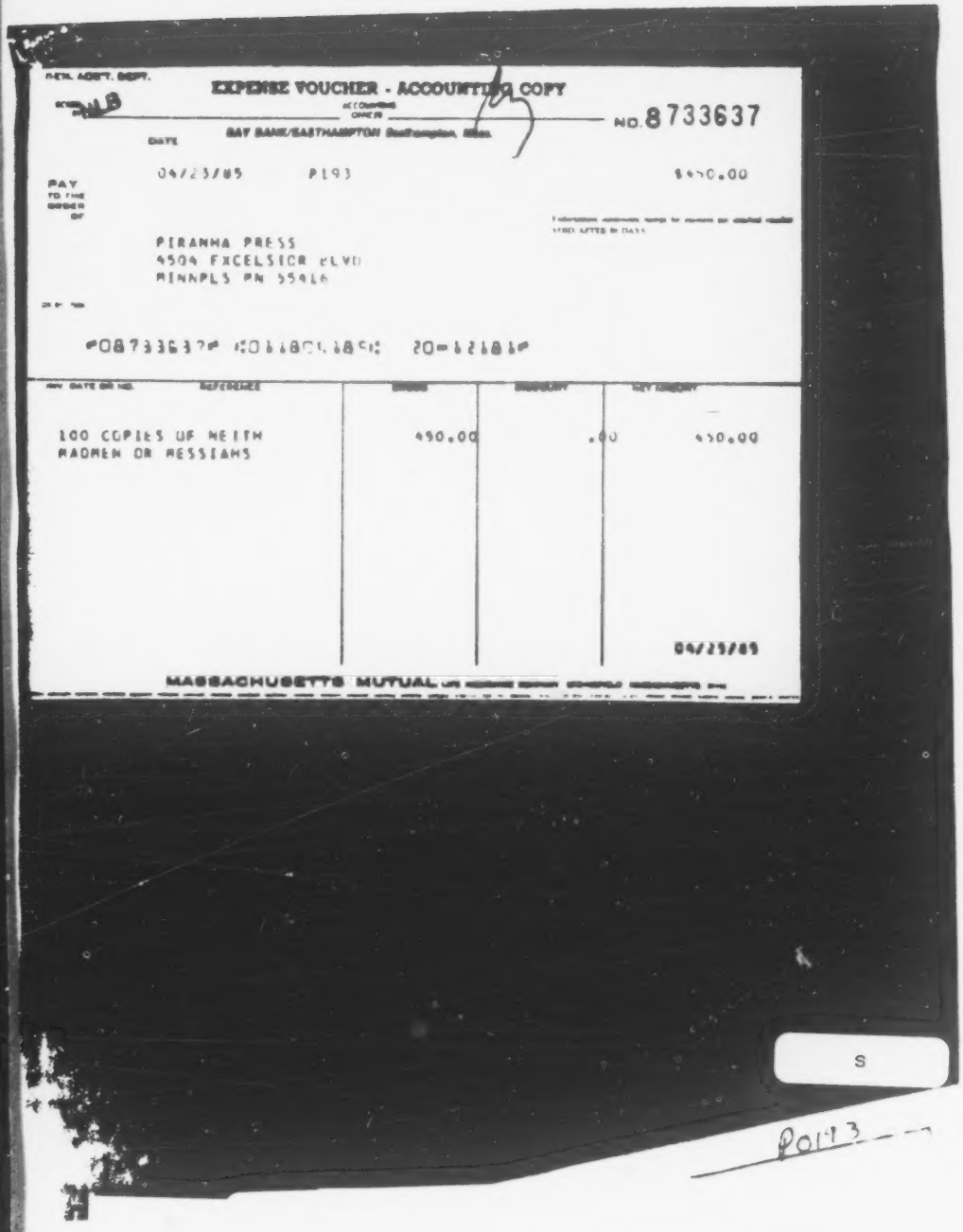
APPROVED DATE 04/22/85 PREPARED BY Heidi Zaremba AUTHORIZED BY Jim A. Berge

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY SPRINGFIELD, MASSACHUSETTS 01111

HMM 4...

[redacted]

R



EXPENSE VOUCHER - ACCOUNTING COPY

NO. 8733637

BAY BANK/EASTHAMPTON (Easthampton, Mass.

DATE 04/23/85

PAY TO THE ORDER OF

PIRANHA PRESS
4504 EXCELSIOR BLVD
MINNPLS MN 55416

#0873363 7# #011801188# 20-621816#

INV. DATE OR NO.	REFERENCE	GROSS	DISCOUNT	NET AMOUNT
100 COPIES OF NEITH MADMEN OR MESSIAHS		490.00	.00	490.00

04/23/85

MASSACHUSETTS MUTUAL

S

P0193

EXPENSE CODE	VOUCHER	DATE	CURRENT MONTH EXPENSE	PRIOR YTD EXPENSE	NEW YTD EXPENSE	EXPENSE NAME
367 202 671	722671	04 18 85	789 00-			
367 202 671	731794	04 12 85	97 56			
367 202 671			691 44-	929 50	238 06	BKS & SUBSCR BOOKS
367 202 682	000416	04 16 85	22 63-			
367 202 682			22 63-	115 57	92 94	BKS & SUBSCR BOOKS
367 202 685			00	91 00	91 00	BKS & SUBSCR BOOKS
367 202 686			00	580 45	580 45	BKS & SUBSCR BOOKS
TOT-A 367 202 6			469 13	4,881 71	5,350 84	
367 202 700	733637	04 25 85	450 00			
367 202 700			450 00	347 82	797 82	BKS & SUBSCR BOOKS
367 202 703			00	72 16	72 16	BKS & SUBSCR BOOKS
367 202 705			00	136 26	136 26	BKS & SUBSCR BOOKS
367 202 706			00	72 00	72 00	BKS & SUBSCR BOOKS
367 202 709			00	74 48	74 48	BKS & SUBSCR BOOKS
367 202 712	730351	04 02 85	21 60			
367 202 712	731057	04 08 85	63 00			
367 202 712	731263	04 09 85	117 24			
367 202 712	734142	04 29 85	153 00			
367 202 712			354 84	405 12	759 96	BKS & SUBSCR BOOKS
367 202 713			00	10 92	10 92	BKS & SUBSCR BOOKS
367 202 714	726214	04 36 85	133 98			
367 202 714	733415	04 24 85	21 45			
367 202 714			155 43	42 55	197 98	BKS & SUBSCR BOOKS
367 202 716	732157	04 16 85	68 90			
367 202 716			68 90	00	68 90	BKS & SUBSCR BOOKS
367 202 717			00	4 16	4 16	BKS & SUBSCR BOOKS
367 202 719			00	150 90	150 90	BKS & SUBSCR BOOKS
367 202 720			00	87 50	87 50	BKS & SUBSCR BOOKS
367 202 721	733351	04 24 85	33 71			
367 202 721	733352	04 24 85	81 54			
367 202 721	733353	04 24 85	80 00			
367 202 721			195 25	422 86	618 11	BKS & SUBSCR BOOKS
367 202 722			00	91 00	91 00	BKS & SUBSCR BOOKS

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY SPRINGFIELD MASSACHUSETTS 01

TO: Byron B. Mattson — Second Vice President

FROM: Jan A. Berger alb
Public Affairs Administrator

MAIL: 2148

MIP: 2308 EXT. 2727

RE: Request for return of check(s) DATE: 5/17/65

This is to request return of the following check(s) to me for special handling*.

Check to:	Amount
Priantha Press	$ 4,000.00

Please call me at extension 2727 for pickup.

*Special handling:

__✓__ Hand delivery

_____ Overnight delivery via Federal express

_____ Other

TO: COMPTROLLER'S DEPT – E166

EXPENSE PAYMENT REQUEST

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE Please call Jan Berger when ready. 2727

ENCLOSURE YES NO

PAYABLE TO Piranha Press

ADDRESS 4504 Excelsior Blvd.
Minneapolis, MN 55416

AMOUNT $ 4,000.00

COMPLETE CHARGE ACCOUNT CODE

MAJOR CODE	SUB-CODE	COST CENTER	AMOUNT
374		700	$4,000.00
Total charges must equal check amount			$4,000.00

State exactly what is desired on voucher.

Promotional appearance by David Durenberger on Monday, May20, at Group Life and Health Conference, Marco Island, FL.

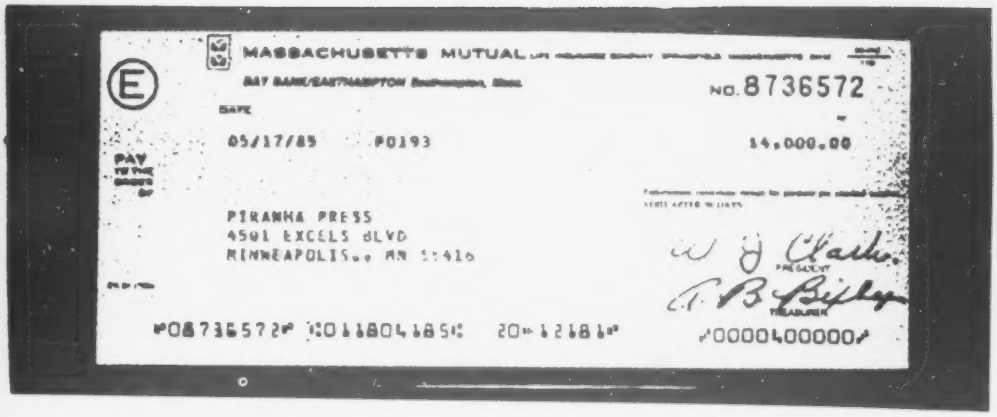
Other Instructions con - program

CURRENT DATE 05/17/85 PREPARED BY Heidi Zaremba AUTHORIZED BY

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, SPRINGFIELD, MASSACHUSETTS 01111

1884

A747 (183)


MASSACHUSETTS MUTUAL

BAY BANK/EASTHAMPTON

NO. 8736572

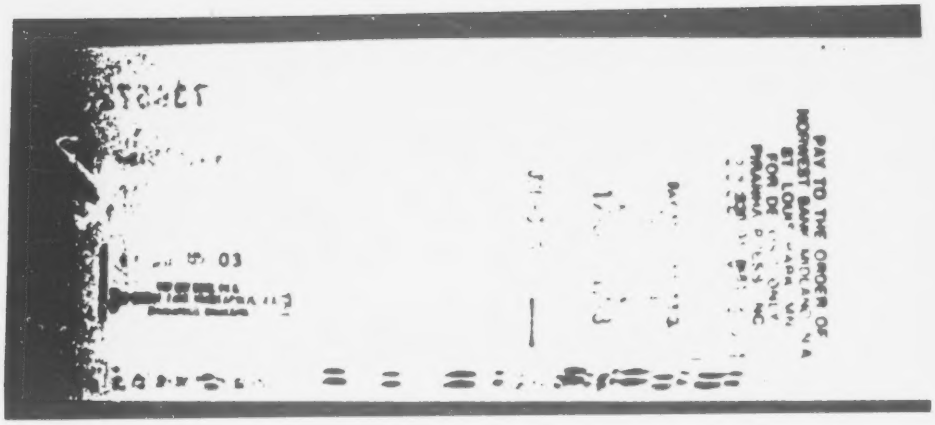
DATE

05/17/85 P0193 14,000.00

PAY TO THE ORDER OF

PIRANHA PRESS
4501 EXCELS BLVD
MINNEAPOLIS, MN 55416

⑈08736572⑈ ⑆011804185⑆ 20⑈12181⑈ ⑈0000400000⑈



Government Program - 1985 - Budgeted $5,000

2/20	Van Cortlandt Society - Telefilm Museum Benefit (CC757) ck	✓	500
2/19	Museum for Long Island - Scholarship	✓	2,000
2/27	Contribution to Florida Conference - 4/22 after autographing by Lew Burdenberger	✓	150
	Florida Charter for Gatlinburg, Oregon + Mathis on 3/28	✓	47222
2/26	Printing Dept for Master for purchase of Tribute Dinner National's Masters Commencement for Long + Mrs Jenkins and Long + Mrs Filippo	✓	360
2/27	Pro Rata share of expenses for testimonial for Paul Kirke 3/6 (Sullivan + Worcester)	✓	2666
3/4	Reagan Moore Reception (check D Jay Stone - MM share 3/85	✓	104893
3/5	Honorable Byron L. Dorgan - RE Cooper at Marco Island, FL on 3/29	✓	2000.03
3/7 + 10	Honorable Guy Vander Jagt - AALU - MM sponsored dinner 3/5/85 in DC.	✓	2000.03
3/7	Long Harold E. Ford for speaking engagement for small Mass Mutual Group in Washington check dated 5/16.	✓	2,000
3/14	Pecanha Press (Promotional appearance by Board Luncheon on Thurs, May 30 at Gigi Life + Health Conference, Marco Isl, FL.	✓	4000
	Long, Edgar H. Jr. - [illegible] agreement dtd [illegible] 23, 1985 - Contd for [illegible]	✓	2,[illegible]

190

1985 HONORARIA

DATE	DESCRIPTION	LC/CC	OTHER	HONORARIA
1/29/85	Honorarium for speaking engagement for MM's 1/29/85 Board of Directors' Dinner Meeting. Check written to Cong. Edgar L. Jenkins.	/706 (Martin's cost ctr.)		$2,000
1/31/85	Dan Rostenkowski article for The Word;$1500 (CC757) sent to Misercordia Home, $500 to Cong. Rostenkowski	374/700	$1500 CC757	$ 500 CC700
3/5/85	Honorarium for speaking engagement at the AALU-MM sponsored dinner in D.C. Check written to the Honorable Guy VanderJagt	374/700		$2,000
3/20/85	Honorarium for speaking engagement at MM R.E. conference at Marco Island, Florida on 3/29/85. Check written to the Honorable Byron L.Dorgan	374/700		$2,000
4/19/85	Honorarium for speaking engagement before an group on 4/30. Check written to Cong. Richard T. Schulze	374/700		$2,000
5/16/85	Honorarium for speaking engagement before a small MM group in Washington. Check written to Cong. Harold Ford	374/700		$2,000
5/17/85	Promotional appearance by David Durenberger on Monday, 5/20/85 at Group Life & Health Conference, Marco Island, Florida. Check to Piranha Press.	374/700		$4,000*
5/28/85	Congressman Archer - Check written to Fellowship Fund Inc.	374/757		$2,000
6/4/85	Honorarium for luncheon speaking engagement in Washington, on Tuesday, 6/4/85. Check written to The Honorable Ronnie Flippo.	374/700		$2,000

* Per legal advisors, this payment was not viewed as an honorarium.

187

1985 HONORARIA (Continued)

DATE	DESCRIPTION	LC/CC	OTHER	HONORARIA
6/10/85	Cong. Rostenkowski - Checks written to Christopher House $1,000, Holy Trinity High School $1,000, The Academy $1,000, American Inst. for Polish Arts & Culture $1,000, & Women's Board-St. Joseph Hospital $1,000.			$5,000
8/20/85	Senator Dole - Checks written to National Hispanic Scholarship Fund $3,000 and Goodwill Industries of Greater Wichita $2,000.			$5,000
8/26/85	Honorarium for speaking engagement at MM Leaders of Leaders Club Agents Conference at the Marriott Hotel in Springfield on 9/6/85. (ck. to Honorable Thad Cochran).	374/700		$2,000
9/9/85	Cong. Pete Stark. Check written to: The Pete Stark Foundation.	363/757		$2,000
12/10/85	Honorarium for speaking engagement at Miami Agency on 12/16/85. Check written to Honorable Joseph D. Early.	374/700		$2,000

Total

29

AA

L. DUNREITH KELLY
LEGISLATIVE RESEARCH

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
Springfield, Massachusetts / organized 1851

April 11, 1975

Eva,
re. Durenberger's Books

Check for $450 should be made payable to: Piranha Press at 4504 Excelsior Blvd, Minneapolis, MN 55416 Meta Murray suggests a cover letter from Barry to Gary L. Diamond: per our agreement, enclosed is a check for $450 for 100 copies of Neither Mad nor Meek to be shipped to Senator Durenberger at his Washington office ~~when it is published~~ ~~ship~~ cc to FL address when the copies is to be sent.

cc: Mr. Murray

for Russell Patterson
Autographing 9

BB

7 Sorting

TO: COMPTROLLER'S DEPT – E186 **EXPENSE PAYMENT REQUEST**

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE: As soon as possible

ENCLOSURE: YES NO

PAYABLE TO: Piranha Press
ADDRESS: 4504 Excelsior Boulevard
Minneapolis, MN 55416

AMOUNT $ 450.00

COMPLETE CHARGE ACCOUNT CODE

MAJOR CODE	SUB-CODE	COST CENTER	AMOUNT
367		700	$450.00
Total charges must equal check amount			$450.00

State exactly what is desired on voucher:
100 copies of "Neither Madmen nor Messiahs."

Other Instructions: Related Conference in Houston (See Memorandum)

CURRENT DATE 04/22/85 PREPARED BY Heidi Zaremba AUTHORIZED BY [signature]

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY SPRINGFIELD, MASSACHUSETTS 01111

A747 (183)

8

CC

EVA M. DION
DIRECTOR OF COMMUNITY AFFAIRS
AND GOVERNMENT RESEARCH

TO Jan

- ☐ FOR YOUR INFORMATION
- ☐ FOR YOUR COMMENTS
- ☑ PLEASE HANDLE Send to
- ☐ PLEASE DISCUSS WITH Jan + Eva
- ☐ PLEASE TAKE UP WITH ME
- ☐ FOR YOUR APPROVAL w/BGs
- ☐ PLEASE FILE
- ☐ FOR YOUR SIGNATURE Carl

PLEASE PREPARE REPLY

- ☐ FOR MY SIGNATURE
- ☐ FOR YOUR SIGNATURE Retain legal docu-ment in file
- ☐ PLEASE RETURN

MASSACHUSETTS MUTUAL
LIFE INSURANCE COMPANY
SPRINGFIELD, MASSACHUSETTS

11A

DD

SCHEDULING INFORMATION

FLK Chair-
sent to
3FC

MTG
TYPE OF EVENT

9/15/86 12 30
EVENT DATE/TIME

Mass Mutual Life insurance Co
GROUP NAME

h 413-583-6653
Saltnik

Contact Jeanne / Barry Gottlieb

Phone 413-730-6051

Key People

Topic

SPEAKERS
Group Size
Honorarium N/A
(amount)
Room Set-Up
Introduction by
Taped (y/n) Transcribed

FOLLOW-UP
Thanks Sent (date)
Photo (y/n) Sent (date)
Photo to Media (date)

LOCATION OF EVENT
Overnight @ the four Seasons
Place Mtg @ the Marriott Copley Place
Room Falmouth Room
Phone Number
Directions
Guests will arrive 12 30/12 45

Membership Lists
Received (y/n)
Computerized (y/n)
Filed (y/n)
Regret Sent
Greeting Sent (y/n)

STAFFING
Briefing Memo
Photo
Speech

N/A
REQUEST DATE

MISCELLANEOUS
travel
to: 9 25pm ↑ Ea #60 10:38↓
return: 4:35↑ ~~Delta~~ 5:29↓
Overnight at the copley plaza

A

SPECIAL COUNSEL HEARING EX. 158

September 10, 1986

Dear Miss O'Dell:

Please accept this letter as my authorization to charge my American Express Account - 3782-800-506-52009 expiration date January, 1988 - all charges incurred by Senator David Durenberger during his stay at the Four Seasons Hotel.

As you are aware, the Senator is holding a reservation for one night only arriving on Sunday evening, September 14th and departing on Monday, September 15th.

As I understand from our Corporate Travel Bureau, you will call Carolyn Stabilo upon receipt of this letter to confirm all the necessary arrangements.

Sincerely,

/jrs

Miss Mike O'Dell
Credit Department
Four Seasons Hotel
200 Boylston Street
Boston, Mass. 02116

B

Dinner - Evening

When - Sept - 15, 1976 - Marriott Copley Place

Topic - Health Care Issues

Honorarium - $2,000 to - Foundation for Future Choice

Reimbursement - Air ex tickets (round trip D.C. to Boston)
($423.00)

Attendees:

Steve Trivoli
Bill Carroll
Rep. Mrs Reed) Chairman of Health Law Committee
Sen Burke
Sen Commissioner Hiam + Nancy Turnbull
Dick Baker
~~Mrs Dunn~~
~~Rep Pierce~~
~~Ray Hathaway~~
Rep Walsh
Staff person - Sen McGinnis's Office

C 408

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

TRANSPORTATION SCHEDULE OF THE DAY

GEORGE MOORE, Asst. Director DEBBIE PELSKI, Coordinator

TRANSPORTATION FOR: Saturday, September 13, 1986
Sunday, September 14, 1986
Monday, September 15, 1986

CAR TRANSPORTATION:

SATURDAY - September 13, 1986

N O N E

SUNDAY - September 14, 1986

Carey: 10:38 p.m. - Sen. Dave Durenberger - Logan to Four Seasons Hotel -E60

MONDAY - September 15, 1986

Til: 6:00 a.m. - Mr. Clark - Home to Boston - W & R - ONLY IF HELI NOT FLYING

Jim: 7:30 a.m. - Mr. Wise - Home to BF

Carey: ~~7:15 a.m. - Sen. Dave Durenberger~~ - Four Seasons Hotel to 209 Musterfield Rd., Concord, MA WAIT - 1200 NOON take him to Marriott Copley Place - WAIT - then Mr. Gottehrer & Sen. Durenberger to Logan and return Mr. Gottehrer to his home.

Jim: 10:30 a.m. - Mr. Gottehrer - Front to Boston - ONLY IF NOT FLYING

D

From:

To:

Date:

Major Code: 363
Sub Code:
Cost Center 757

- [x] A747 Expense Payment Request
- [ ] T136A Travel Authorization
- [ ] R803 Requisition for Supplies
- [ ] R738 Requisition for Machine
- [ ] R1394 Furniture, Equip, etc. Request
- [ ] Memo
- [ ] Letter
- [ ] Envelope

Documentation sent re tax exempt status w/ a copy of check.

A747/T136A

Pay to: Foundation for Future Choice

For/Purpose:

Contribution in lieu of honorarium for Sen. David Durenberger.

Amount: $2,000 —

R803

Form No.:

Quantity:

Description:

R1394

Date Wanted:

Work and Items Required:

Re letter -
E H needs above check & take with him at 10:30 Monday 9/15.

Sen Durenberger will address a group of representatives from various insurance companies, the Ins. Commissioners Chairmen of the 2 Healthcare Committees and others.

Please give me a copy of the letter & this form. Thanks - Jan

E

403

MEMORANDUM

TO: Senator
FR: Mary B.
DATE: 9/12/86

RE: Luncheon remarks in Boston on Monday

At a luncheon at the Marriott at Copley Plaza sponsored by Massachusetts Mutual Life Insurance Corp., you will be speaking to about 12 gentlemen representing the top management of insurance interests in Mass. Also a few key members of the Mass. Legislature who are involved in health policy will be there. It is to be very informal, and you already know some of those coming to lunch. Lunch begins at 12:45 and your remarks will begin after lunch. About 15-20 minutes followed by 10-15 minutes of Q&A.

Those coming:

Barry Gottehrer	CEO of Mass. Mutual
Ned Dever	Mass. Mutual's lobbyist in Boston
Steve Tringale	Life Insurance Association of Mass.
Bill Carroll	" " " "
Dick Baker	Mutual State Insurance of Mass.
Jack Delaney	Bank of Boston
Ray Hathaway	Gov't. Relations, John Hancock Insurance
Senator John Burke	Chairman of Senate Health Committee
Rep. John (Jack) McNeil	Chairman of House Health Committee
Rep. Mike Walsh	Vice-Chair of House Insurance Committee
Rep. Steve Pierce	Member, Mass. House of Reps.
Peter Hiam	State Insurance Commissioner
Nancy Turnbull	Staff member with Peter Hiam

F

What they would like to have you talk about:

1. They'd like to hear your general views on where you see the health care industry going in the next few years. These global views could be accompanied by comments on what's on the current legislative agenda for health in the Senate as Congress screams to a close:

   a. Floor debate on reconciliation is scheduled to begin Wednesday. The health provisions in recon. now COST $2.2 billion. It's still debatable as how this will be handled on the floor.

   b. The sequestration resolution agreed to on Friday gives the Senate 5 more legislative days (that is, until this Friday) to come up with the savings needed to meet the G-R-H target so we won't have to spend precious time finding a G-R-H fix that can be agreed on.

2. **Tax reform** and the health-related provisions:

   See attached memo from Alexander

3. Your pending **risk pool legislation** -
I've attached a copy of your statement and your bill, S.2403 that contains the risk pool provision.

A few points you could make:

a. You've decided to not go ahead with risk pools at this time:

b. The bill has some specific requirements about how the insurance would be structured - maximum premium amounts, lifetime maximum coverages, etc. You have questions as to whether federal law needs to be this prescriptive to the states on how to structure their plans.

c. Nine states currently have pools, and 2 passed legislation this year to create pools. Massachusetts is not one of these 11.

d. Many comments we have received indicate that there is some confusion about how the pools would be funded. Funding for the pools is left up to the states. However the bill does contain a penalty provision for the purpose of forcing states to set up a pool, and that is a tax on employers' premium contributions. Some believe that this tax would fund the pools and that it isn't fair to require this of private employers who offer employees health insurance, and not require it of employers that don't offer health plans nor of local and state government employers. Not so, unless of course a state wanted to do this.

G

MASSACHUSETTS MUTUAL

No. 8801470

09/11/06

DUPLICATE - NON-NEGOTIABLE

FOUNDATION FOR FUTURE GREECE

397

H

398

NCIA –
Pls add to honoraria, noting line code
303 757
Jan

TO: COMPTROLLER'S DEPT – E100 **EXPENSE PAYMENT REQUEST**

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE: Please call Annette Holmes on ext. 2169 when check is ready

ENCLOSURE: YES (NO)

PAYABLE TO: Foundation for Future Choice

ADDRESS:

AMOUNT $2,000.

COMPLETE CHARGE ACCOUNT CODE:

MAJOR CODE	SUB-CODE	COST CENTER	AMOUNT
363	300	757	$2,000.
Total charges must equal check amount			$2,000.

State exactly what is desired on voucher:

Contribution in lieu of honorarium for Sen. David Durenberger.

Other Instructions:

CURRENT DATE 9/12/86 PREPARED BY: A. Holmes AUTHORIZED BY

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, SPRINGFIELD, MASSACHUSETTS 01111

A747 (183)

42

403

TO: COMPTROLLER'S DEPT – E166 **EXPENSE PAYMENT REQUEST**

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE: Please call Annette Holmes on ext. 2169 whenchheck is ready

ENCLOSURE: YES (NO)

PAYABLE TO: Foundation for Future Choice

ADDRESS:

AMOUNT: $2,000.

COMPLETE CHARGE ACCOUNT CODE

MAJOR CODE	SUB-CODE	COST CENTER	AMOUNT
363	~~000~~ 200	757	$2,000.
Total charges must equal check amount			$2,000.

State exactly what is desired on voucher:

Contribution in lieu of honorarium for Sen. David Durenberger.

9/11/86.
Ck. #880,470 dated 9/11/86 to B&A for handling. kg/ah

Other Instructions:

CURRENT DATE 9/12/86 PREPARED BY A. Holmes AUTHORIZED BY

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, SPRINGFIELD, MASSACHUSETTS 01111

747 (183)

406

K

70193

PIRANHA

PRESS

Gary L. Diamond
Publisher

SEP 2 2 A.M.

DATE: September 18, 1986

TO: Barry Gottehrer
1295 State St.
Springfield, MA 01111

OK + pay
per BG
9/25/86
cc 700 - [illegible]
367

INVOICE

100 copies of "Prescription for Change" @ $9.93 ea.---------- $ 993.00

Sales Tax .60 per book---------- 60.00

Shipping and Packing---------- 50.00

TOTAL DUE---------- $1103.00

SEP 20 1986

Dear Barry:

Enclosed please find the 100th copy of Prescription for Change by Senator Dave Durenberger. Your other requested 99 copies will be coming in two boxes via U.P.S. Should you have any questions, please do not hesitate to call. Your check can be made payable to Piranha Press.

Thank you for your business.

367 202 700

Sincerely,

Gary Diamond

P.S. The enclosed book is personally autographed by Dave.

4804 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

31-403 44

381

TO: COMPTROLLER'S DEPT – E166 **EXPENSE PAYMENT REQUEST**

(NOT TO BE USED AS A SUBSTITUTE FOR PURCHASE ORDER)

MAIL DATE: ASAP

ENCLOSURE: (YES) NO

PAYABLE TO: Westpark Travel-Capitol Hill

ADDRESS: 214 Massachusetts Ave., NE
Suite 140
Washington, D.C. 20002

AMOUNT: $423.50

COMPLETE CHARGE ACCOUNT CODE:

MAJOR CODE	SUB-CODE	COST CENTER	AMOUNT
210	200	700	$423.50
Total charges must equal check amount			$423.50

State exactly what is desired on voucher:

Round trip airline tickets (first class) for Senator David Durenberger - D.C. to Boston

Other Instructions

CURRENT DATE 9/22/86 PREPARED BY: J. Saletnik AUTHORIZED BY: B Gallehue/jp

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, SPRINGFIELD, MASSACHUSETTS 01111

A747 (183)

M 386

WESTPARK TRAVEL-CAPITOL HILL

214 MASSACHUSETTS AVENUE, N.E. • SUITE 140 • WASHINGTON, D.C. 20002 • (202) 544-8202

INVOICE

SALES PERSON: 41 ITINERARY/INVOICE NO. 0005190 DATE: 12 SEP 8
CUSTOMER NBR: 024444 GRAG2L PAGE: 1

TO: MR BARRY GOTTEHRER ATTN JEAN
MASSACHUSETTS MUTUAL LIFE INS. CO
1295 STATE STREET
SPRINGFIELD, MA 01111

THANK YOU FOR FAVORING US WITH YOUR TRAVEL BUSINESS. WE MUST PAY THE AIRLINES EACH WEEK FOR ALL TICKETS ISSUED. WE WILL APPRECIATE RECEIVING PAYMENT FOR YOUR TICKETS PROMPTLY.

PLEASE REMIT FROM THIS INVOICE.

FOR: DURENBERGER/DAVID F SEN

14 SEP 86 - SUNDAY					
AIR	LV WASHINGTON NATL	925P	EASTERN	FLT:60	DELUXE NIGH
	AR BOSTON	1038P	NON-STOP		
	RESERVED SEATS	4B			
15 SEP 86 - MONDAY					
AIR	LV BOSTON	405P	DELTA	FLT:571	FIRST CLASS
	AR WASHINGTON NATL	524P	NON-STOP		
	RESERVED SEATS	2B			

AIR TICKET/S EA7846507387 FOR DURENBERGER DAVID F 423.50

SUB TOTAL 423.50

TOTAL AMOUNT 423.50

SEP 17 A.M.

388

CUSTOMER COPY

EXPENSE VOUCHER - COMPTROLLER'S COPY

CHECKED BY _____ ACCOUNTING OFFICER _____ NO. 8805112

BAY BANK/EASTHAMPTON Easthampton, Mass.

DATE

10/08/86 00787 $423.50

PAY TO THE ORDER OF

Endorsement constitutes receipt for payment per attached voucher
VOID AFTER 90 DAYS

WESTPARK TRAVEL - CAPITOL HILL
214 MASSACHUSETTS AVE NE
SUITE 140, WASHINGTON, DC 20002

CK 01 (REV)

⑈0880511 2⑈ ⑆011804185⑆ 20⑈121816⑈

INV. DATE OR NO. REFERENCE	GROSS	DISCOUNT	NET AMOUNT
ROUND TRIP AIRLINE TICKETS (FIRST CLASS) FOR SENATOR DAVID DURENBERGER DC TO BOSTON	423.50	.00	423.50
			10/08/86

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, SPRINGFIELD, MASSACHUSETTS 01111

PAYMENT GUARANTEED HOTEL CONFIRMATION

GUEST Senator David Durenberger

HOTEL Four Seasons Hotel

ADDRESS 200 Boylston Street

CITY/STATE Boston, MA

MASSACHUSETTS MUTUAL
LIFE INSURANCE COMPANY
1295 STATE STREET
SPRINGFIELD, MASSACHUSETTS 01111
TEL: 413-788-8411

BFF TRAVEL/MASS MUTUAL 572023

TELEPHONE NO 617-338-4400 ARRIVAL DATE Sun.Sept.14,1986 DEPARTURE DATE Mon.Sept.15,1986

ROOM TYPE Double/Overlooking Garden RATE $ $180.00+tax(corp.rate)

CONFIRMED	WITH	BY	DATE RESERVED ON
	Chris @ Hotel Resv.	Carolyn Stabile	September 9,1986

REMARKS

389

PAYMENT GUARANTEED FOR ARRIVAL ANY TIME IF YOUR PLANS CHANGE, YOU MUST CANCEL THE RESERVATION BY 4:00 P.M. LOCAL T
BILLED FOR ONE NIGHT
T 300-1084

P

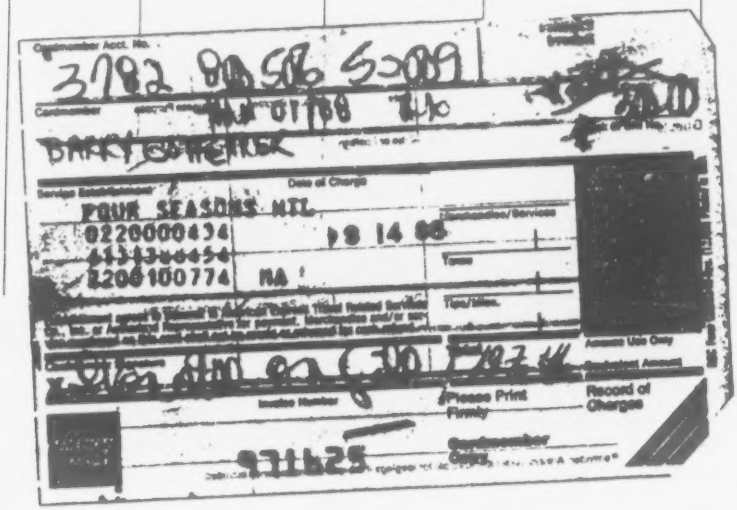
Four Seasons Hotel
BOSTON
200 BOYLSTON STREET
BOSTON, MASSACHUSETTS 02116
(617) 338-4400

FOLIO

GUEST

ROOM
RATE
NO. PERS
FOLIO
PAGE
ARRIV
DEPART
DEPOSIT

DATE	REFERENCE NO	DESCRIPTION	DEBIT/CREDIT



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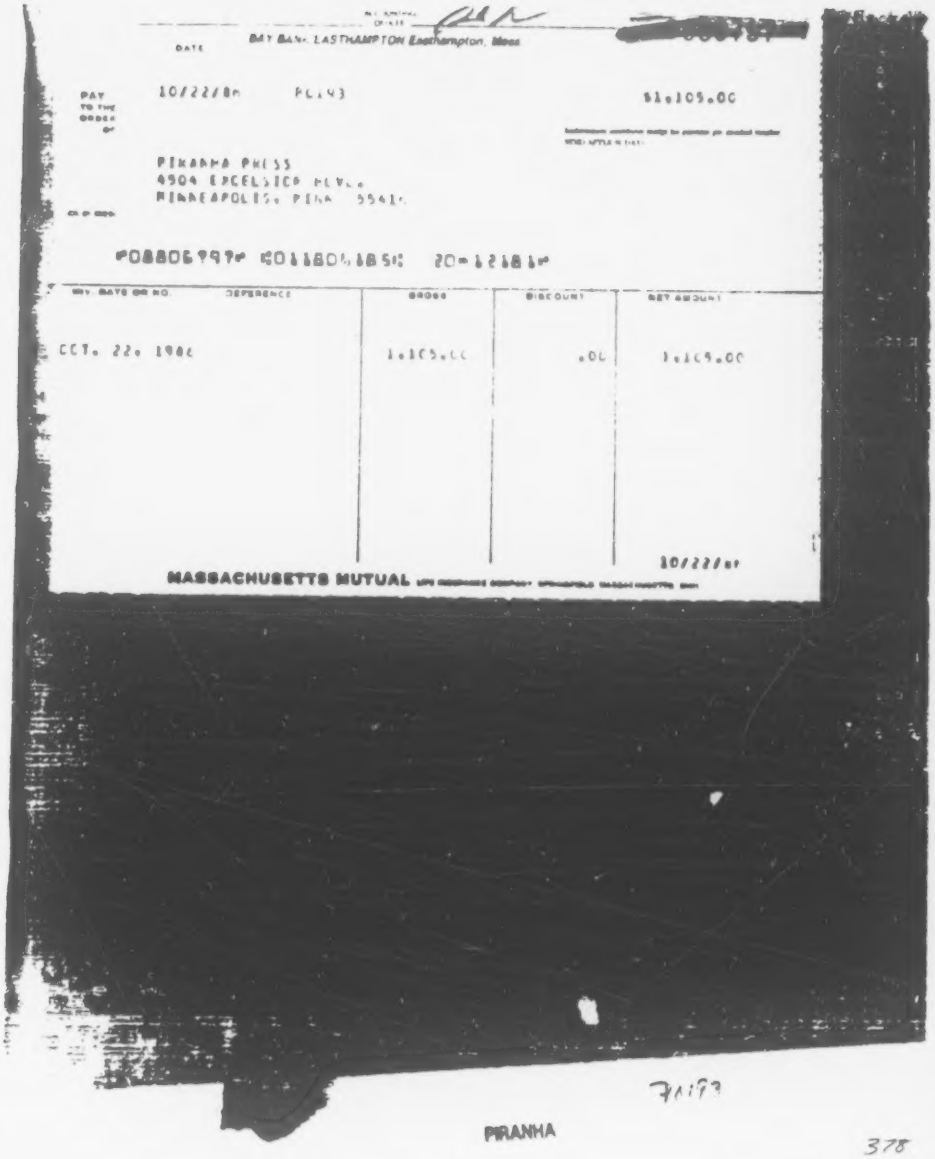

BAY BANK LAST HAMPTON Easthampton, Mass

DATE

PAY TO THE ORDER OF 10/22/80 PC143 $1,105.00

PIRANHA PRESS
4904 EXCELSIOR BLVD.
MINNEAPOLIS, MINN 55416

⑈08806999⑈ ⑆011804185⑆ 20-12181⑈

MY DATE OR NO.	REFERENCE	GROSS	DISCOUNT	NET AMOUNT
OCT. 22, 1980		1,105.00	.00	1,105.00

10/22/80

MASSACHUSETTS MUTUAL

74173

PIRANHA

378

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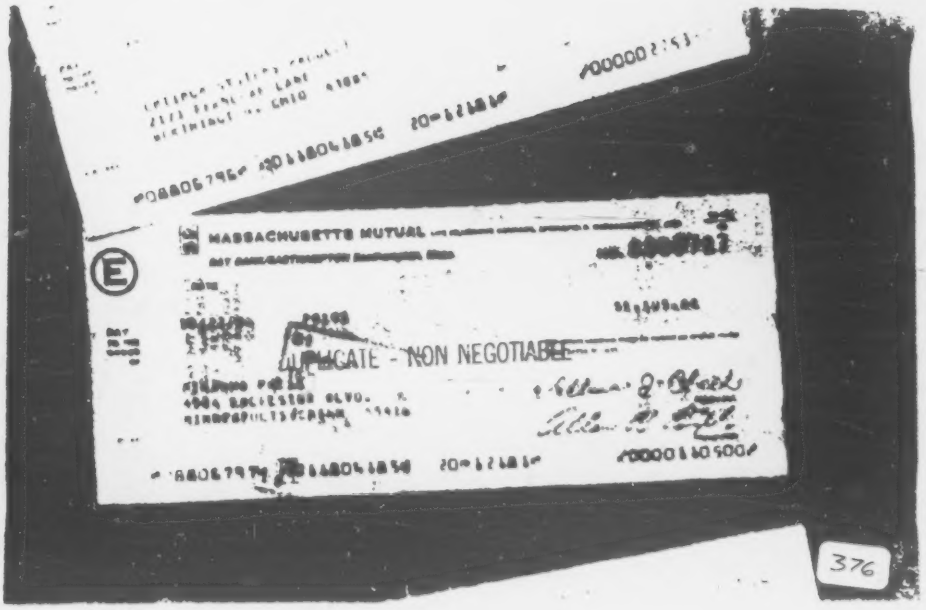
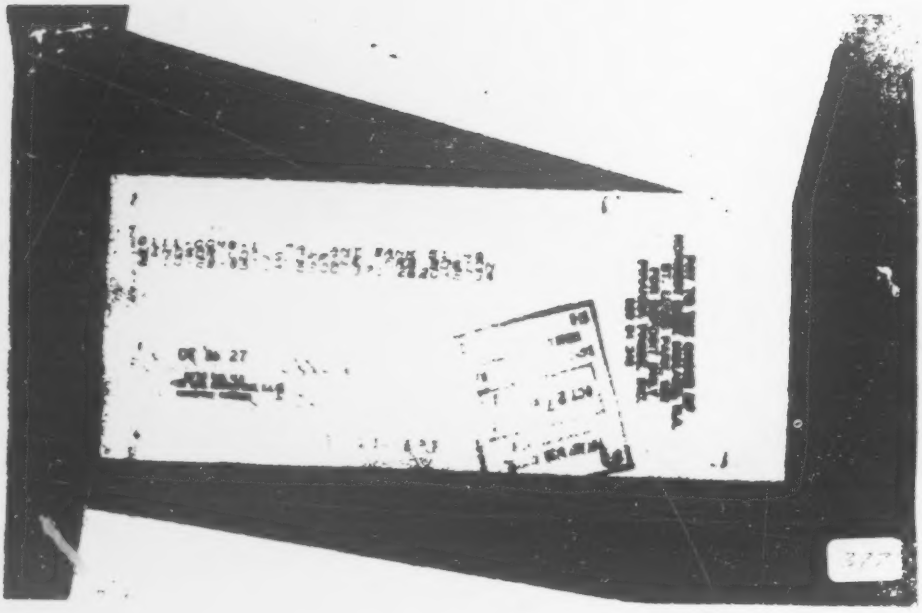
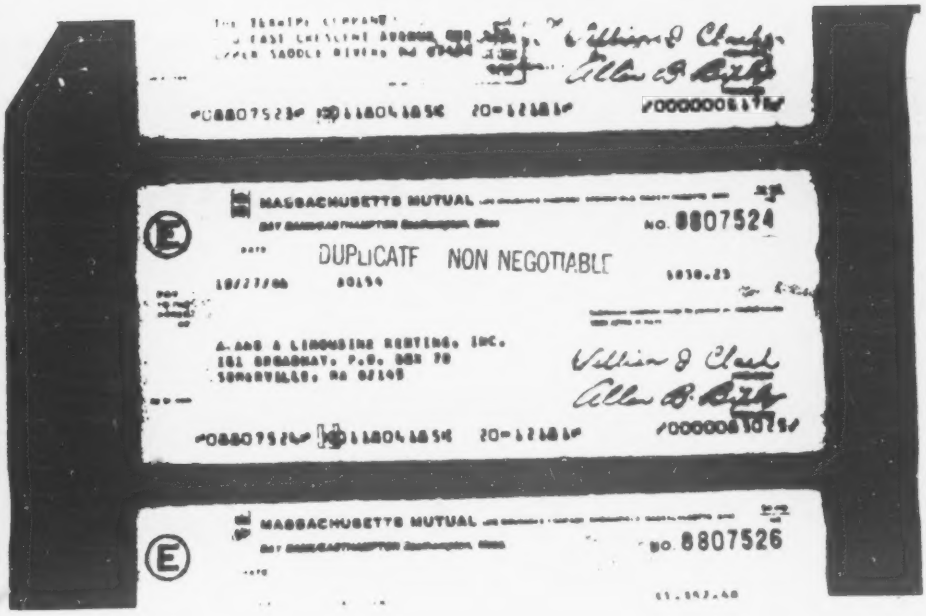

MASSACHUSETTS MUTUAL
DUPLICATE - NON NEGOTIABLE
376





MASSACHUSETTS MUTUAL

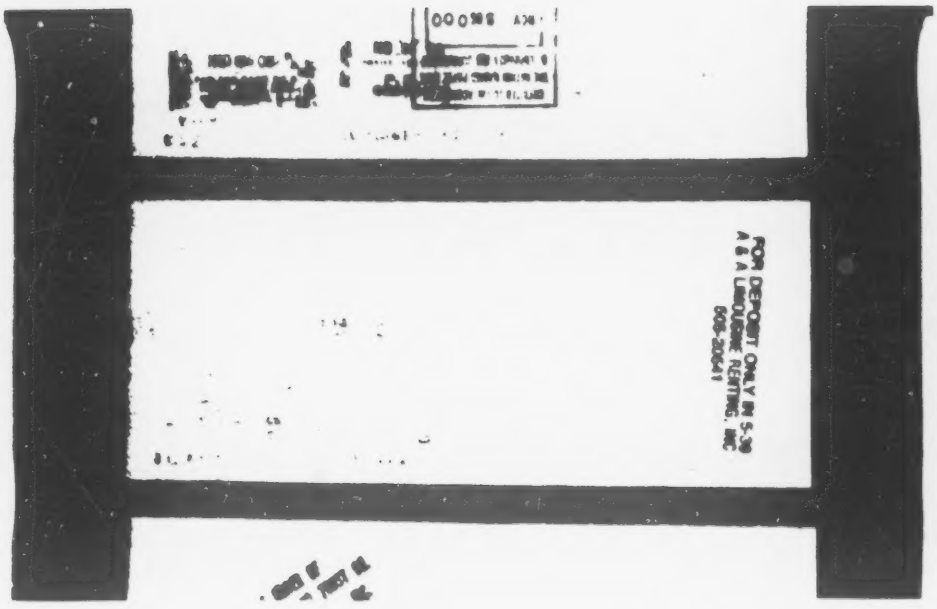
NO. 8807524

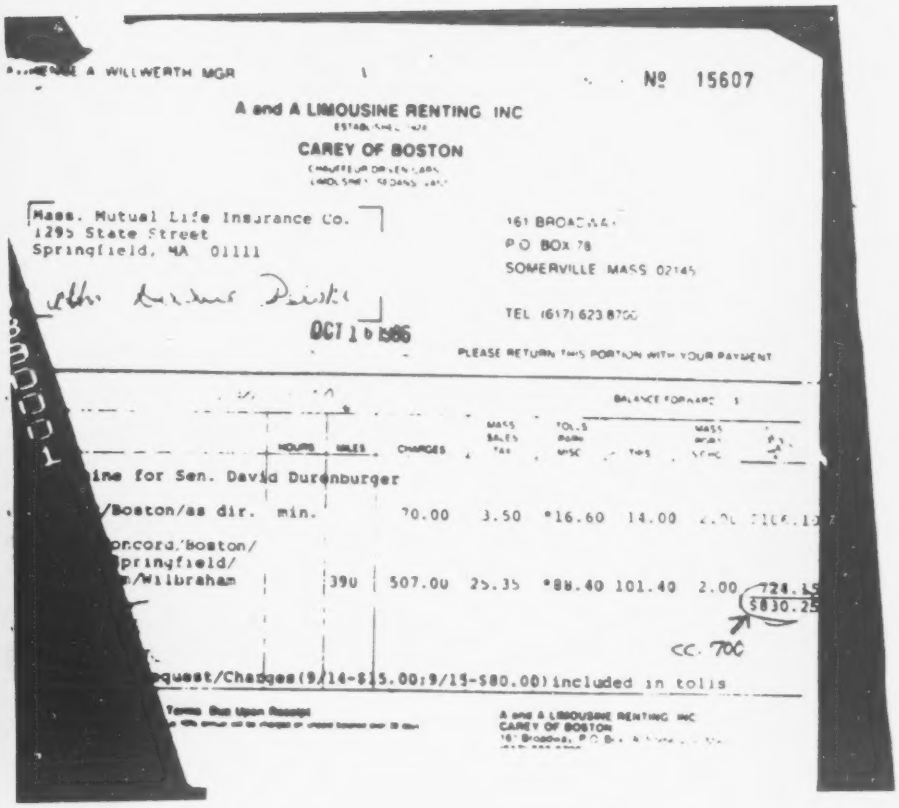
DUPLICATE NON NEGOTIABLE

A-AAA A LIMOUSINE RENTING, INC.
181 BROADWAY, P.O. BOX 70
SOMERVILLE, MA 02143

MASSACHUSETTS MUTUAL

NO. 8807526


FOR DEPOSIT ONLY IN S-30
A & A LIMOUSINE RENTING, INC
005-30041



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№ 15607

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ESTABLISHED

CAREY OF BOSTON

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LIMOUSINE SEDANS

Mass. Mutual Life Insurance Co.
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Springfield, MA 01111

161 BROADWAY
P O BOX 78
SOMERVILLE MASS 02145

TEL (617) 623 8700

OCT 1 6 1986

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

BALANCE FORWARD

	HOURS	MILES	CHARGES	MASS SALES TAX	TOLLS Parking MISC	TAXI	MASS SURCH MISC	
ine for Sen. David Durenburger								
/Boston/as dir. min.			70.00	3.50	*16.60	14.00	2.00	106.10
oncord/Boston/ Springfield/ n/Wilbraham		390	507.00	25.35	*88.40	101.40	2.00	724.15 5830.25

cc. 700

quest/Charges(9/14-$15.00;9/15-$80.00)included in tolls

Terms Due Upon Receipt

A and A LIMOUSINE RENTING INC
CAREY OF BOSTON
161 Broadway, P O Box

complete in duplicate

2-5009

12142

AUTHORIZATION FOR PAYMENT

MEMORIAL HOSPITAL
1901 Arlington Street
Sarasota, Florida 33579

PLEASE RETURN CHECK TO THE MEDICAL STAFF OFFICE TO BE GIVEN TO THE SPEAKER ON FRIDAY MORNING, 11/29/85, at 9:00 a.m.

Name Senator Dave Durenberger

Date November 26, 1985

St. or P.O. #

Acct. # 5060

City & State

Requested by George A. Bishopric, M.D.

Quantity	Description	Unit Price	Amount
1	For speaking engagement, Clinical Conference, Friday, November 29, 1985: "Liability - Medicine - Government"		$250.00

DB

Approved _____
director

SPECIAL
COUNSEL
HEARING
EX. 159

A

memorial hospital
SARASOTA FLORIDA
GENERAL FUND

No. 122511

Southeast Bank N.A.
Five Points Banking Center
1401 Main Street
Sarasota, Florida 33577

63-495
631

DATE 11/27/85

AMOUNT

Pay The sum of 250dol's00cts $250.00

TO THE ORDER OF * Senator Dave Durenberger [illegible]

CHAIRMAN

TREASURER

⑈122511⑈ ⑆063104956⑆ 005 959895⑈ ⑈00000 25000⑈

B

Pay to the order of Piranha Press
Sunday Bum Rundown

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. PAUL BANK, MN
FOR DEPOSIT AT ONLY
PIRANHA PRESS, INC.

PAID
SOUTHEAST BANK N.A.

CLINICAL CONFERENCE MINUTES
November 29, 1985

The speaker of the morning was Senator David Durenberger, United States Senator from Minnesota. Senator Durenberger spoke on the topic of "Rising Costs and Expectations in Health Care" (a Risk Management program).

Senator Durenberger began his talk with recollections of how life was in his state and community during the depression. He noted that his very difficult period of time created a desire in citizens to protect the country against any recurrence of that situation. This led to government involvement of a much more intensive sort in social programs, and in programs designed to protect some of the considered basic rights and comforts of the American people. He described, for example, how subsidies for housing had led, in his own particular case, with low interest rates and the effects of the depression and housing shortage for growth of a $500.00 down payment in his early marriage to a present home of $360,000.00 value, plus an in-town apartment, all on the basis of the original down payment and resale price increases.

He noted that national health care insurance activity programs started about the same time with, to some extent, some of the same effects. The government originally supported health care by making health care plans a deductible expense to the employer, but free of taxes to the recipient. This was followed by Medicare and Medicaid. All of these resulted in a tax on working people to pay for what has become a combination of programs for which no recipient is paying or has paid. These "health care programs" have developed in a way so that they do not actually cover health protection activities such as physical examinations, immunizations, etc. They do not really cover any kind of "well care".

The above described system has led to a loss of incentive to the physician to practice conservative medicine. Subsequently we have seen rapid rise in high tech and high cost medicine surgyer, with coronary bypass surgery being the most common operation in the United States today; hysterectomies, some suspected unnecessary, increasing similarly. The government has been giving a blank check for medical technology in surgical specialties. There are no rewards, presently, for careful and cognitive medical practice. There is particularly no reward for high skilled and informed physicians.

The present malpractice rates, Senator Durenberger noted, do not reflect the experience of an individual physician and his record in malpractice. A neurosurgeon with clean record and excellent judgment pays the same premium as one who has had multiple judgments against him. This supplies an increasing premium rate with the basic rate of the lowest risk, family practice, being much higher than ever considered possible. The malpractice insurance thinks that equal rights for all individuals in a specialty is reasonable. Senator Durenberger thinks that it "borders on fraud".

Senator Durenberger noted that advances in medicine have resulted in a high expectation and high standards of perfection and results, in turn leading towards increased liability.

D

Welfare has been neglected. Poor prenatal care and availability of premature acute care units present a combination of high risk and great expectations with great increased liability risk for the obstetrician.

Holding down malpractice risks does not depend, in his opinion, on control of insurance, doing "something to" the lawyers. Better prenatal care and other wellness programs must not be forgotten. Physicians must become health practitioners and not just cleanup men after damages done from poor personal care.

Senator Durenberger has looked into, again, a 1964 proposal relating to hospital "accident insurance". This sort of insurance would be one that the hospital must carry, which would be indicated for physicians, optional for patients. Benefits would be paid according to a specific going rate for misadventure experience, such as now already carried through in workman's compensation. A loss of income benefits would be also on an "accident" type basis, with payments to continue at the designated rate during the lifetime of the patient or the lifetime of his disability. Lump sums on estimated lifetime earnings would be avoided.

Senator Durenberger felt that such an accident type of blanket insurance coverage would eliminate much of the legal maneuvering experienced and now such a problem with our courts. He noted that under the present system only a small percentage of the money returned by verdicts gets to the patient and that, in fact, the vast majority of malpractice cases are still being decided in the favor of the defendant.

Senator Durenberger's very thoughtful and provocative presentation was followed by a question and answer period which Senator Durenberger extended, graciously, past the scheduled hour.

The meeting was adjourned at 10:05 a.m.

George A. Bishopric, M.D.
Director, Medical Education

GAB/esb

E

Be a Guest
of Miller & Schroeder at monthly luncheon meetings featuring guest speakers from the ranks of government and industry: CEO's of leading corporations, U.S. Senators and Representatives, Governors, and other ranking government officials.
Next Forum
Monday, June 10, 1985
Sheraton Airport Inn
I-494 at 24th Avenue
Bloomington, Minnesota
11:30 to 1:30
Cocktails 11:30
Lunch 12:00
Call (612) 893-8941 for reservations by June 7.
Seating is limited.
Miller & Schroe

SPECIAL
COUNSEL
HEARING
EX. 160

A

Miller & Schroeder Municipals, Inc.
NORTHWESTERN FINANCIAL CENTER
7900 XERXES AVENUE SOUTH
MINNEAPOLIS MN 55431

First Bank Saint Paul
First National Bank of Saint Paul
332 Minnesota Street
Saint Paul, Minnesota 55101

97751
72-
982

	DATE	AMOUNT
PAY	06/04/85	$2,000.00

TO THE ORDER OF
DAVE DURENBERGER

PROTECTED BY 8U48420 $2000.00

Miller & Schroeder Municipals, Inc.

⑈097751⑈ ⑆096000014⑆ 20-94899⑈

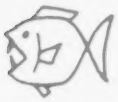
Miller & Schroeder Municipals, Inc.

97751

06/04/85	102020	D.DURENBURG		
HONORARIUM	HONORARIUM - M&S FORUM JUNE 10, 1985		855200	$2,000.00
		TOTAL		$2,000.00

B

PIRANHA



PRESS

Gary L. Diamond
Publisher

June 15, 1985

Ms. Christina W. Fleps
O'Connor & Hannan
Suite 800
1919 Pennsylvania Avenue NW
Washington, DC 20006

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Ms. Fleps:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Miller & Schroeder Forums on a date to be scheduled with Senator Durenberger's office.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD · MINNEAPOLIS, MINN 55416 PHONE (612) 920-7711

C

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Anne Kelly
Ms. Kitty Gamble

D

APPEARANCE SCHEDULE

Date	Place	Amount
To be scheduled with Senator Durenberger's Office	Minneapolis, Minnesota	$2,000 Plus Expenses

E

CURTIN, MAHONEY & CAIRNS
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

RICHARD T. CURTIN
MICHAEL C. MAHONEY
JOHN A. CAIRNS
SUSAN L. SEJMEYER
DOUGLAS L. CARNEY
DONNA E. HANBERY
DEANNE M. GRECO
EDWARD C. ANDERSON
MICHAEL W. SCHLEY
JEFFREY C. ROBBINS
KENNETH COREY-EDSTROM
DAVID J. STEINGART

4150 MULTIFOODS TOWER
MINNEAPOLIS CITY CENTER
MINNEAPOLIS, MINNESOTA 55402
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TELEX 29183
TELEPHONE (612) 333 5411

1920 N STREET N.W.
SUITE 420
WASHINGTON, D.C. 20036
TELECOPIER (202) 833 8344
TELEX 64 588
TELEPHONE (202) 887 0718

OF COUNSEL
ALEX M. GANDAL
ADMITTED IN D.C. AND OHIO

REPLY TO
Minneapolis

June 17, 1985

Christina W. Fleps, Esq.
O'Connor & Hannan
Suite 800
1919 Pennsylvania Avenue N.W.
Washington, D.C. 20006-3483

SENATOR DAVE DURENBERGER--SPEAKING ENGAGEMENT
OUR FILE NO. 01468-007

Dear Ms. Fleps:

We have received payment for Senator Durenberger's appearance at the Miller & Schroeder Forum on June 10, 1985; however, we must ask that the check be made payable to Piranha Press, Inc. We would appreciate your help in returning this check to Miller & Schoeder and having a new check issued.

Please contact the undersigned if you have any questions in connection with this matter.

Thank you for your help.

Very truly yours,

Susan Anderson

SUSAN K. ANDERSON
Legal Assistant

Enclosure

SKA0617851

MILLER & SCHROEDER

EXPENSE APPROPRIATION & AUTHORIZATION

_____ Airline Tickets _____ Car Rental _____ Travel Advance

__x__ Check Request _____ Hotel _____ Expense Authorization

6/24/85 Date Submitted

NAME Lou DeMars

Purpose of Trip

Project Name M&S Forum

Check Payee Piranaha Press

Destination

NOTE: This check is to replace check originally issued to Durenberger, which is being returned to Accounting

Date of Departure Time

Date of Return Time PLEASE GIVE NEW CHECK TO BERTIE

Description of Expense to be Incurred and Reason

Honorarium - M&S Forum 6/[illegible]85

Amount Requested/Approved $ 2,000 Date Needed 6/2[illegible]/85

Requested By LGD/ad Approved By

G

Miller & Schroeder Municipals, Inc.
NORTHWESTERN FINANCIAL CENTER
7900 XERXES AVENUE SOUTH
MINNEAPOLIS, MN 55431

First Bank Saint Paul

98770
22
98C

	DATE	AMOUNT
PAY	06/24/85	$2,000.00

TO THE ORDER OF

PIRANAHA PRESS

PROTECTED BY 8U48420 $2000.00

Miller & Schroeder Municipals, Inc.

⑈098770⑈ ⑆096000064⑆ 20⑈94899⑈

Miller & Schroeder Municipals, Inc.

98770

06/24/85	102020	PIRANAHA PR		
P&S FORUM	HONORARIUM - M&S FORUM 6/10/85		855200	$2,000.00
		TOTAL		$2,000.00

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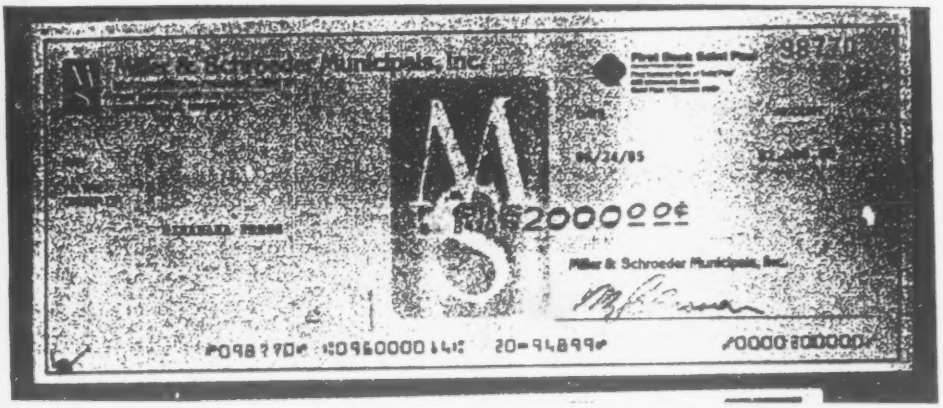
Miller & Schroeder Municipals, Inc.
First Bank Saint Paul
98770
06/24/85
$ 20000 00¢
Miller & Schroeder Municipals, Inc.
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⑈0000200000⑈

Miller & Schroeder Municipals, Inc.
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[illegible] NICOLLET AVENUE SOUTH
MINNEAPOLIS MN 55431

First Bank Saint Paul
[illegible]

98710

DATE	AMOUNT
06/24/85	$840.00

PAY
TO THE ORDER OF

OFFICIAL OFFICE ACCOUNT
OF U.S. SENATOR
DAVE DURENBERGER

PAID TO THE
84842C [illegible] $840.00¢

Miller & Schroeder Municipals, Inc.

[illegible]

⑈098710⑈ ⑆096000014⑆ 20-94899⑈

Miller & Schroeder Municipals, Inc.

98710

06/24/85	102020	D.DURENBERG		
AIRFARE-FORD	AIRFARE - M&S FORUM 6/10/85		855200	$840.00
		TOTAL		$840.00

K

Toll Free Minnesota (800) 862-6002
Toll Free Other States (800) 328-6122

Miller & Schroeder Municipals, Inc.

Northwestern Financial Center, 7900 Xerxes Avenue South, Minneapolis, Minnesota 55431 • (612) 831-1500

June 25, 1985

Ms. Susan K. Anderson
Curtin, Mahoney & Cairns
4150 Multifoods Tower
Minneapolis, Minnesota 55402

Dear Ms. Anderson:

As requested in your letter of June 17th to Christina Fleps of O'Connor & Hannan in Washington, D.C., we are enclosing a check payable to Piranha Press for Senator Durenberger's appearance here in Minneapolis on June 10th at our Miller & Schroeder Forum luncheon.

Sincerely,

Bertie Dahl, Secretary to
Louis G. DeMars

Enclosure

cc: Christina Fleps, Esq.

L

M & S FORUMS

10/24/80	Senator James Exon - D-Nebraska Marquette Inn - Minneapolis
11/7/80	Senator William Roth, Jr. - R-Delaware Radisson - St. Paul
12/16/80	Dr. Walter Heller - University of Minnesota Registry - Bloomington
12/17/80	Senator Robert Dole - R-Kansas Registry - Bloomington
2/13/81	Senator John Chafee - R-Rhode Island Granada Royale - Bloomington
3/11/81	Senator Alan Cranston - D-California Minneapolis Radisson
4/3/81	Cecil Andrus Minneapolis Hilton
4/22/81	Senator Mark Hatfield - R-Oregon L'Hotel de France - Bloomington
5/26/81	Senator Dave Durenberger - R-Minnesota Holiday Inn State Capitol - St. Paul
8/4/81	Senator Jake Garn - R-Utah Sheraton Airport - Bloomington
8/26/81	Senator Pat Leahy - D-Vermont Normandy Inn - Minneapolis
10/28/81	Professor Art Naftalin - Humphrey Institute Radisson South - Bloomington
11/13/81	Senator Gary Hart - D-Colorado Radisson Plaza - St. Paul
1/12/82	Senator Richard Lugar - R-Indiana Bloomington Marriott

M

M & S FORUMS
Page Two

2/16/82	Senator George Mitchell - D-Maine Radisson Plymouth
4/12/82	Congressman Phil Crane - R-Illinois Congressman Ken Holland - D-South Carolina Congressman Martin Sabo - D-Minnesota Normandy Inn - Minneapolis
5/3/82	Congressman Bill Frenzel - R-Minnesota Congressman Marty Russo - D-Illinois Marriott Hotel - Bloomington
5/10/82	Senator David Boren - D-Oklahoma Congressman Henson Moore - R-Louisiana Sheraton Airport Inn - Bloomington
6/7/82	Congressman Richard Gephardt -D-Missouri Congressman James Martin - R-North Carolina Registry Hotel - Bloomington
6/14/82	Congressman John Duncan - R-Tennessee Congressman Wyche Fowler - D-Georgia Holiday Inn International - Bloomington
10/21/82	Senator Dale Bumpers - D-Arkansas Marriott Bloomington
2/4/83	Senator Ernest Hollings - D-South Carolina Sheraton Ritz Hotel - Minneapolis
4/18/83	Senator Donald Riegle - D-Michigan Sheraton Midway Hotel - St. Paul
6/6/83	Senator Bennett Johnston - D-Louisiana Congressman Martin Sabo - D-Minnesota The Saint Paul Hotel - St. Paul
6/20/83	Senator Spark Matsunaga - D-Hawaii Senator Steve Symms - R-Idaho Registry Hotel - Bloomington

N

M & S FORUMS
Page Three

7/11/83	Senator Max Baucus - D-Montana Congressman Tom Loeffler - R-Texas The Saint Paul Hotel - St. Paul
7/25/83	Senator Charles Grassley - R-Iowa Senator David Pryor - D-Arkansas The Hotel Leamington - Minneapolis
8/18/83	Congressman Silvio Conte - R-Massachuetts Congressman Ed Jenkins - D-Georgia The Saint Paul Hotel - St. Paul
9/12/83	Senator Jim Sasser - D-Tennessee Senator John Chafee - R-Rhode Island Sheraton Airport Inn - Minneapolis
9/26/83	Senator Dave Durenberger - R-Minnesota Congressman Henson Moore - R-Louisiana Congressman Beryl Anthony, Jr. - D-Arkansas Normandy Inn - Minneapolis
10/12/83	Senator William Cohen - R-Maine Congressman Robert Matsui - D-California Sheraton Park Place Hotel - Minneapolis
10/24/83	Congressman James Shannon - D-Massachusetts Congressman William Thomas - R-California The Hotel Leamington - Minneapolis
11/7/83	Senator Bob Packwood - R-Oregon Congressman Byron Dorgan - D-North Dakota The Saint Paul Hotel - St. Paul
11/21/83	Dr. Walter Heller - University of Minnesota Amfac Hotel - Minneapolis
12/15/83	Congressman Gerry Sikorski - D-Minnesota Congressman Thomas Downey - D-New York Sheraton Ritz Hotel -Minneapolis

M & S FORUMS
Page Four

6/29/84	Senator Alan Cranston - D-California Registry Hotel - Irvine, California
1/15/85	Jerry Brown, Chairman - National Commission on Industrial Innovation The Saint Paul Hotel - St. Paul
2/4/85	Congressman Thomas Downey - D-New York Hotel Leamington - Minneapolis
2/25/85	Congressman Bill Lowery - R-California Congressman Robert Matsui - D-California Westin South Coast Plaza - Costa Mesa, California
3/18/85	Congressman Willis Gradison - R-Ohio Congressman Bruce Vento - D-Minnesota The Saint Paul Hotel - St. Paul
4/15/85	Senator Steve Symms - R-Idaho Congressman James Oberstar - D-Minnesota Sheraton Park Place Hotel - Minneapolis
4/29/85	Congresswoman Barbara Kennelly - D-Connecticut Sheraton Midway - St. Paul
5/10/85	Senator Alan Cranston - D-California Bel-Air Hotel - Beverly Hills, California
5/20/85	Congressman Byron Dorgan - D-North Dakota Congressman Vin Weber - R-Minnesota Normandy Inn - Minneapolis
6/10/85	Senator Dave Durenberger - R-Minnesota Congressman Richard Durbin - D-Illinois Sheraton Airport Inn - Bloomington
7/1/85	Congressman Carroll Campbell - R-South Carolina Congressman Hal Daub - R-Nebraska Registry Hotel - Bloomington

P

7/2/85	Senator Pete Wilson - R-California Congressman Wyche Fowler - D-Georgia Hotel Inter-Continental - San Diego, California
7/22/85	Congressman Bill Frenzel - R-Minnesota Congressman Martin Sabo - D-Minnesota Registry Hotel - Bloomington
7/29/85	Senator Joseph Biden, Jr. - D-Delaware Registry Hotel - Bloomington
9/23/85	Congressman John Duncan - R-Tennessee Registry Hotel - Bloomington
11/4/85	Hennepin County Commissioner John Derus International Market Square - Minneapolis
11/25/85	Lieutenant Governor Harriett Woods - Missouri Sheraton Midway - St. Paul
12/9/85	Congressman Dick Schulze - R-Pennsylvania Registry Hotel - Bloomington
12/30/85	Congressman Tom Daschle - D-South Dakota Leamington Hotel - Minneapolis
2/28/86	Congressman Tim Wirth - D-Colorado The Saint Paul Hotel - St. Paul
3/10/86	Senator James McClure - R-Idaho The Saint Paul Hotel - St. Paul
3/24/86	Congressman Robert Matsui - D-Illinos Congressman Wyche Fowler - D-Georgia Sheraton Park Place Hotel - Minneapolis
4/21/86	Senator John Melcher - D-Montana Congressman Philip Crane - R-Illinois Embassy Suites Hotel - St. Paul

Q

M & S FORUMS
Page Six

5/12/86	Congressman Jack Fields - R-Texas Congressman James Oberstar - D-Minnesota International Market Square - Minneapolis
5/19/86	Congressman Hal Daub - R-Nebraska Representative Bruce Vento - D-Minnesota The Saint Paul Hotel - St. Paul
6/16/86	Congressman William Coyne - D-Pennsylvania Congressman Ronnie Flippo - D-Alabama Sheraton Park Place Hotel - Minneapolis
6/23/86	Senator Paul Simon - D-Illinos Registry Hotel - Bloomington
7/14/86	Congressman Jim Bates - D-California Congressman Thomas Manton - D-New York Sheraton Midway - St. Paul
8/8/86	President Gerald Ford Seasons Restaurant - Coon Rapids
8/18/86	Senator Charles Grassley - R-Iowa Congressman Martin Sabo - D-Minnesota Registry Hotel - Bloomington
9/15/86	Congressman Byron Dorgan - D-North Dakota Congressman Guy Vander Jagt - R-Michigan Sheraton Airport Inn - Bloomington
10/20/86	Congressman Bill Frenzel - R-Minnesota Sheraton Park Place Hotel - Bloomington
11/17/86	Senator Dale Bumpers - D-Arkansas Sheraton Airport Inn - Bloomington
12/15/86	Congressman Thomas Luken -D-Ohio Sheraton Park Place Hotel - St. Louis Park

R

M & S FORUMS
Page Seven

2/25/87	Dr. Walter Heller - University of Minnesota Seasons Restaurant - Coon Rapids
3/16/87	Senator David Boren - D-Oklahoma Congressman Robert Matsui - D-California Embassy Suites Hotel - Bloomington
4/13/87	Congressman John Duncan - R-Tennessee Congressman Hal Daub - R-Nebraska Airport Hilton - Bloomington
5/11/87	Congressman Bill Archer - R-Texas Congressman Donald Pease - D-Ohio Ritz Hotel - Minneapolis
5/29/87	General Alexander Haig Skywood Inn - Fridley
6/15/87	Congressman David Obey - D-Wisconsin Congressman Phil Crane - R-Illinois Congressman Harold Ford - D-Tennessee Registry Hotel - Bloomington
7/13/87	Congressman William Ford - D-Michigan Sheraton Midway Hotel - St. Paul
8/10/87	Congressman Byron Dorgan - D-North Dakota Congresswoman Barbara Kennelly - D-Connecticut Registry Hotel - Bloomington
9/14/87	Congressman Dick Schulze - R-Pennsylvania Sheraton Midway Hotel - St. Paul
9/27/87	Congressman Jack Kemp - R-New York Skywood Inn - Fridley
10/19/87	Congressman Judd Gregg - R-New Hampshire Congressman Jim Bunning - R-Kentucky The Whitney Hotel - Minneapolis

S

M & S FORUMS
Page Eight

1/22/88	Reverend Jesse Jackson Skywood Inn - Fridley
5/13/88	Mayor Andrew Young - Atlanta, Georgia The Saint Paul Hotel - St. Paul
8/1/88	Congressman Bruce Vento - D-Minnesota Lt. Governor L. Douglas Wilder - Virginia Holiday Inn Town Square - St. Paul
9/19/88	Congressman Martin Sabo - D-Minnesota Normandy Inn - Minneapolis

T

Irene Briggs -
921 - 4300

5/20 Harold Frye
→ Montgomery
would like to schedule for May 20th Annual Mtg. City Medical Society
Tues. Dinner 7:00
8:00
Bethesda Marriott
@ Beltway
OK
told 2K was price 921-4300

SPECIAL
COUNSEL
HEARING
EX. 161

A

FROM JUDI/DD 3/3

MONTGOMERY COUNTY MEDICAL SOCIETY
15855 CRABBS BRANCH WAY • ROCKVILLE, MARYLAND 20855 • (301) 921-4300

#2K

5/29 → Remarks in Bethesda

April 9, 1986

agreed to: 4/1/86
received: 4/15/86

Honorable David Durenberger
Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

I would like to express my appreciation for your willingness to accept our invitation to speak at our May 20, 1986 General Membership Meeting. We would like you to cover the broad topic of the 99th Congress and health legislation and its impact on physicians and the general public.

The meeting will be held at the Bethesda Marriott on Pooks Hill Road. It begins with a cocktail hour at 6:00 p.m. and dinner at 7:00 p.m. with the program following at approximately 8:00 p.m. We generally have 200 physicians in attendance.

Because of the Medical Society's proximity to Washington, many of our physicians have great interest in health care legislation.

If you or your staff have any questions concerning this engagement feel free to contact me. Thank you again for accepting our invitation.

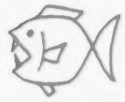
Sincerely,

Harold F. Frye
Executive Director

HFF:jab

B

PIRANHA



PRESS

Gary L. Diamond
Publisher

MAY 12 1986

May 5, 1986

PAID #1645 5/13

Mr. Harold F. Frye
Executive Director
Montgomery County Medical Society
15855 Crabbs Branch Way
Rockville, MD 20855

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Frye:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the General Membership Meeting on May 20, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

020-138

C

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

D

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
May 20, 1986	6:30-9:00 p.m.	Rockville, Maryland	$2,000

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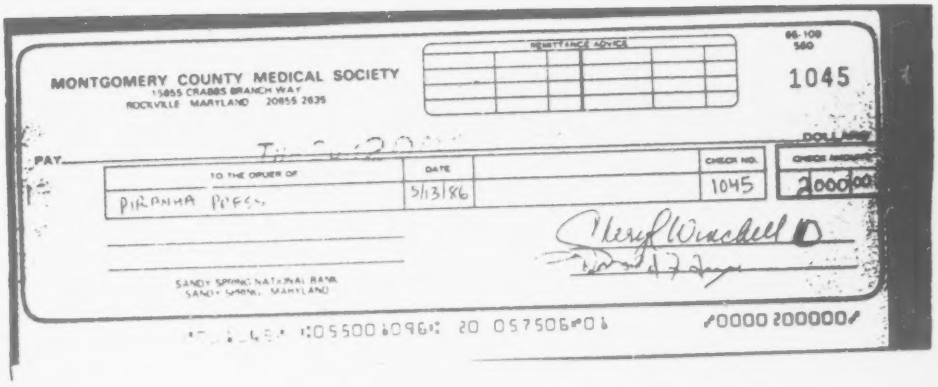

MONTGOMERY COUNTY MEDICAL SOCIETY
15855 CRABBS BRANCH WAY
ROCKVILLE MARYLAND 20855 2635

REMITTANCE ADVICE

1045

PAY

TO THE ORDER OF: PIRANHA PRESS

DATE: 5/13/86

CHECK NO. 1045

DOLLARS

CHECK AMOUNT 2000 00

Sheryl Winchell

SANDY SPRING NATIONAL BANK
SANDY SPRING, MARYLAND

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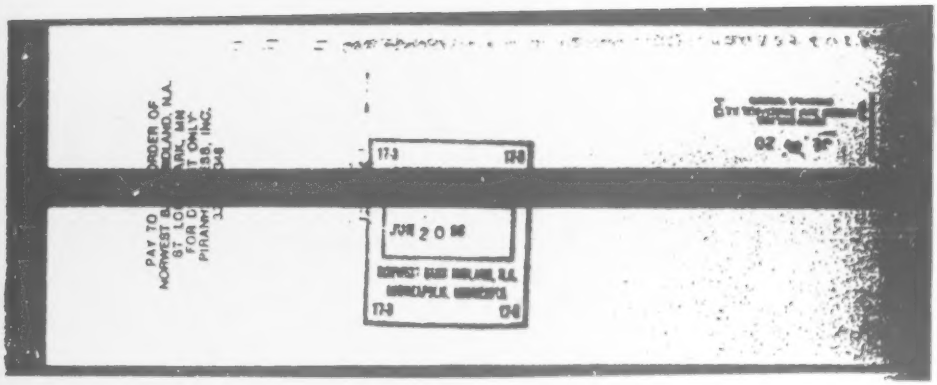
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MINNEAPOLIS, MINNESOTA
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SCHEDULING INFORMATION

SPEECH — 5/20/86 see bottom
TYPE OF EVENT — EVENT DATE/TIME

Montgomery County Medical Society
GROUP NAME

Contact Harold Frye
Phone 921-4300
Key People

Topic 99th C : health legislation ; its impact on physicians ; the general public

LOCATION OF EVENT
Place Bethesda Marriott
Room In the Ballrooms (entire wing)
Phone Number 897-9400
Directions
Pooks Hill Rd

STAFFING
Briefing Memo CK
Photo
Speech

sometime in March
REQUEST DATE

SPEECHES
Group Size 200
~~Honorarium~~ $2K AO
(amount)
Room Set-Up
Introduction by Donald W. Wiczer Pres. of Med. Soc.
Taped (y/n) Transcribed Sweet (y/n)

POLLOW-UP
Thanks Sent (date)
Photo (y/n) Sent (date)
Photo to Media (date)
Membership Lists
Received (y/n)
Computerized (y/n)
Filed (y/n)
Regret Sent
Greeting Sent (y/n)

copy of sheet sent to CK 5/14

MISCELLANEOUS
Cocktails - 6:00
Dinner - 7:00
Remarks - 8:00

H

GENERAL MEMBERSHIP MEETING MINUTES

May 20, 1986

The General Membership Meeting was held at the Bethesda Marriott.

I. Donald W. Wiczer, M.D., President opened the meeting by introducing new members and guests.

Dr. Wiczer presented the following awards:

A. A scholarship and award of Special Promise in Health Care to Miss Erica Wei-Ru Wu and special plaques to the two runners up, Ahsan Arozulla and John Paul Sverha.

B. A special award to Eugene A. Rosenberger, M.D. in recognition of his contribution to the public health of our community upon his retirement.

C. Plaques to Hazel Pruitt and LaVelle Van Houten in recognition of their retirement as employees of the Montgomery County Medical Society and counselors for the Patient Advocacy Referral Service for over 14 years.

Mrs. Lydia Kaplan, President of the Medical Society Auxiliary, reported on the Auxiliary's commitment to support physicians and the Medical Society in this rapidly changing environment.

Dr. Wiczer announced the next General Membership Meeting will be held September 16, 1986. This will be the first of two political meetings. Candidates for the U.S. Senate, U.S. Congress, and Governor will be invited to participate in that meeting.

Dr. Wiczer announced that the Medical Society is considering endorsing candidates for the 1986 primary election.

Dr. Wiczer announced that as of today the NIH Federal Credit Union received approval for the Medical Society to make available to its members and their staffs the services of the Credit Union.

II. U.S. Senator David Durenburger from Minnesota presented a provocative speech on the need for we the people to change to adapt to the great society which developed during the 50's, 60's and early 70's. He suggested that physicians needed to take the lead in working with politicians, their patients, and the general public in developing incentives for patients to stay healthy.

III. Upon MOTION duly seconded, it was recommended that the Minutes of the April 15, 1986 General Membership Meeting be approved as published. The MOTION passed.

General Membership Meeting Minutes
May 20, 1986
Page Two

IV. Rajindra K. Sarin, M.D., Chairman, presented the Membership Committee report. Upon MOTION duly seconded, it was recommended that the Membership Committee report be approved as published. The MOTION passed.

V. No old business or new business was brought to the attention of the Society.

VI. There being no further business the meeting adjourned at 9:20 p.m.

Respectfully submitted,

Lawrence H. Fink, M.D.
Secretary

HFF/LHF:jab

5386 2/5

FINLEY, KUMBLE, WAGNER, HEINE, UNDERBERG, MANLEY & CASEY
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
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1140 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
(202) 659-8300
CABLE: VERITAS
TELEX 440345
TELECOPIER (202) 466-7554

100 SOUTH FLOWER STREET, SUITE 3213, LOS ANGELES, CALIFORNIA 90017, (213) 489-4601
101 WEST BROADWAY, SAN DIEGO, CALIFORNIA 92101, (619) 231-8700
4400 MacARTHUR BOULEVARD, SUITE 300, NEWPORT BEACH, CALIFORNIA 92660, (714) 851-2255
177 BRICKELL AVENUE, MIAMI, FLORIDA 33131, (305) 371-2600
401 EAST PRATT STREET, BALTIMORE, MARYLAND 21202, (301) 244-0298
425 PARK AVENUE, NEW YORK, N.Y. 10022, (212) 371-5900
9100 WILSHIRE BOULEVARD, BEVERLY HILLS, CALIFORNIA 90212, (213) 550-6100
1120 CONNECTICUT AVENUE, N.W., WASHINGTON, D.C. 20036, (202) 857-4000

for Mr. Burks

659-8300

January 15, 1986

The Honorable David Durenberger
United States Senate
Washington, D.C. 20510

Re: Invitation to Speak to the Board of Directors of the National Association of Alcoholism Treatment Programs, Inc., on February 5 or 6.

Dear Senator Durenberger:

On behalf of the Board of Directors of the National Association of Alcoholism Treatment Programs, Inc. (NAATP), and Mr. Harold A. Swift, President of Hazelden and NAATP's Vice President, your distinguished colleague from Minnesota, it is my pleasure to invite you to address the Board on February 5 or 6, 1986, at its regularly scheduled quarterly session at the Capital Hilton Hotel here in Washington. Because of your long-standing and demonstrated interest in the issues of proper and adequate treatment and rehabilitation of alcoholism and drug abuse patients, as well as adequate reimbursement, you are ideally suited to visit with the Board members while they are here in Washington. They would, of course, provide you with your usual honorarium for this event.

NAATP, as you know, represents both not-for-profit and proprietary treatment providers, specializing in inpatient, outpatient and residential treatment services. With over 450

Room -

SPECIAL
COUNSEL
HEARING
EX. 162

A

members nationwide, NAATP represents the state-of-the-art treatment and rehabilitation services for the alcoholic and drug dependent patient. It is my fervent wish that you will be able to join us on one of those two days, consistent with your very busy legislative schedule.

With every good wish, I remain

Yours very truly,

Frederick H. Graefe

FHG/mm

TO : Mike Manley, Linda

From: Judi/DD

5386

FINLEY, KUMBLE, WAGNER, HEINE, UNDERBERG, MANLEY & CASEY
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
FORMERLY PERITO, DURRE AND PENCO, A PROFESSIONAL CORPORATION
1140 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
(202) 659-6300
CABLE: VERITAS
TELEX: 440846
TELECOPIER: (202) 466-7564

for Ag bucks

700 SOUTH FLOWER STREET
SUITE 3210
LOS ANGELES, CALIFORNIA 90017
(213) 489-4981

101 WEST BROADWAY
SAN DIEGO, CALIFORNIA 92101
(619) 231-8700

4400 MacARTHUR BOULEVARD
SUITE 300
NEWPORT BEACH, CALIFORNIA 92660
(714) 851-2295

777 BRICKELL AVENUE
MIAMI, FLORIDA 33131
(305) 371-2600

660 WORLD TRADE CENTER
401 EAST PRATT STREET
BALTIMORE, MARYLAND 21202
(301) 244-0299

425 PARK AVENUE
NEW YORK, N.Y. 10022
(212) 371-6800

9100 WILSHIRE BOULEVARD
BEVERLY HILLS, CALIFORNIA 90212
(213) 550-8100

1129 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
(202) 857-4000

Feb. 5th
@1:00 @Capitol Hilton

-Fred

January 15, 1986

The Honorable David Durenberger
United States Senate
Washington, D.C. 20510

Re: Invitation to Speak to the Board of Directors of the National Association of Alcoholism Treatment Programs, Inc., on February 5 or 6.

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NAATP, as you know, represents both not-for-profit and proprietary treatment providers, specializing in inpatient, outpatient and residential treatment services. With over 450

Fred said to "send it to Mal [illegible] -- NS NB we're included.

C

members nationwide, NAATP represents the state-of-the-art treatment and rehabilitation services for the alcoholic and drug dependent patient. It is my fervent wish that you will be able to join us on one of those two days, consistent with your very busy legislative schedule.

With every good wish, I remain

Yours very truly,

Frederick H. Graefe

FHG/mm

D

Board of Directors
Robert J. Lindewald
President
St. Benedict's ACT
Ogden, Utah

Mike Carter
Program Director
Keystone Foundation
Canton, South Dakota

Allen Drum
Director
Addiction Recovery Units
F-N, Medical Corp.
Denver, Colorado

James F. Emmert
Executive Director
Charlotte Treatment Center
Charlotte, North Carolina

Rune Ferms
President
Edgehill Newport
Newport, Rhode Island

Joel Gumerman
Executive Director
Azure Acres
Sebastopol, California

Margie W. Johnson
Executive Director
Tennyson Center
St. Vincent Medical Center
Toledo, Ohio

Scott D. Martin
President
Kettle Moraine Hospital
Oconomowoc, Wisconsin

Dennis H. McElfresh
Vice President
Tennyson Medical Services
Corporation
Park Ridge, Illinois

Eugene McWilliams
President
Tropicwood Recovery Centers
Birmingham, Alabama

Robert A. Rundio
President
St. Luke's Behavioral
Health Center
Phoenix, Arizona

Richard A. Samson, Ph.D.
President
Comprehensive Care Corp.
Newport Beach, California

John T. Schwartzrock
Administrator
The Betty Ford Center
Rancho Mirage, California

Gerald D. Shuman
Vice President
Addiction Recovery Corp.
Needham, Massachusetts

Harold A. Swift
Administrator
Hazelden Foundation
Center City, Minnesota

Officers
Dennis H. McElfresh
President

Robert A. Rundio
Immediate Past President

Harold A. Swift
Vice President

Richard A. Samson, Ph.D.
Secretary

Robert J. Bronaran
Treasurer

Staff
Michael Q. Ford
Executive Director

Laura Paul
Associate Director

Victoria Kagan
Manager, Admin. Services

Richard D. Weissman
National Health Care Consultant

Frederick H. Graefe, Esq.
General Counsel
Kirkpatrick & Lockhart
Washington, D.C.

NATIONAL ASSOCIATION OF
ALCOHOLISM TREATMENT PROGRAMS, INC.

January 23, 1986

MEMORANDUM

TO: Members, NAATP Board of Directors

FR: Michael Q. Ford, Executive Director

RE: Upcoming Board Meeting & Enclosed Agenda Package

"NAATP STORMS WASHINGTON" the newspapers will say! We have two days of breathless political intrigue in store for you in the Nation's Capital, February 5th & 6th.

As stated in previous communications, Board members should be arriving at the Capital Hilton the evening of Tuesday, February 4th. From then, the schedule looks as follows:

Wednesday, February 5, 1986

Morning

Time: 9:00am - 12:00 noon

Place: Senate Room, Capital Hilton, 1001 16th St., N.W. (at K St.), Washington, D.C.

Event: Discussion of Legislation, DRGs & Research
Led by Michael Ford and Fred Graefe

Guests: Roger Meyer, M.D.
Randy Teach
Hon. David Durenberger (invited)

A luncheon has been arranged, in the hotel, following the conclusion of the morning meeting.

E

Afternoon

After lunch, NAATP Board Members are urged to visit their Senators and Congressmen, or their staff, to discuss the issues raised in the morning session. Please take the time to make these appointments, or feel free to call Fred Graefe's Secretary, Melnie (202/659-8300), in Washington, D.C., and she will be happy to make the appointments for you.

2082 Michelson Drive • Suite 304 • Irvine, CA 92715 • (714) 476-8204

600085

Evening

Time: 5:00pm - 8:00pm

Place: Room 120 (please note change), U.S. Capitol Building

Event: NAATP Congressional Reception

We will host a catered reception in one of the most beautiful rooms in the Capitol. This will be, primarily, a social occasion, allowing Board members to make acquaintances with Members of Congress and their staff, HHS officials, and health care association leaders.

Thursday, February 6, 1986

Time: 8:30am - 2:30pm

Place: Senate Room, Capital Hilton

Event: Meeting of the Board of Directors

Your agenda package for the Board Meeting is enclosed. This is the meeting where we assess our activities of the previous year and look toward new strategies for the coming year. We will be discussing budget, goals and objectives, membership, our new ICP survey and, of course, the report of the NAATP Board Structure Task Force.

I look forward to seeing you in my home town.

F

Board of Directors
Robert J. Bedmarek
President
St. Benedict's ACT
Ogden, Utah

Mitz Cantoli
Program Director
Keystone Foundation
Canton, South Dakota

Allen Drum
Director
Addiction Recovery Units
P.S.L. Medical Corp.
Denver, Colorado

James F. Emmert
Executive Director
Charlotte Treatment Center
Charlotte, North Carolina

Frank Fenerla
President
Edgehill Newport
Newport, Rhode Island

Lisa Gunnerson
Executive Director
Azure Acres
Sebastopol, California

Margo W. Johnson
Executive Director
Tennyson Center
St. Vincent Medical Center
Toledo, Ohio

Scott D. Mann
President
Kettle Moraine Hospital
Oconomowoc, Wisconsin

Orville H. McElfresh
Vice President
Parkside Medical Services
Corporation
Park Ridge, Illinois

Eugene McWilliams
President
Brookwood Recovery Centers
Birmingham, Alabama

Robert A. Rundio
President
St. Luke's Behavioral
Health Center
Phoenix, Arizona

Richard A. Santoni, Ph.D.
President
Comprehensive Care Corp.
Newport Beach, California

John T. Schwartzlose
Administrator
The Betty Ford Center
Rancho Mirage, California

Gerald D. Shulman
Vice President
Addiction Recovery Corp.
Waltham, Massachusetts

Harold A. Swift
Administrator
Hazelden Foundation
Center City, Minnesota

Officers
Orville H. McElfresh
President

Robert A. Rundio
Immediate Past President

Harold A. Swift
Vice President

Richard A. Santoni, Ph.D.
Secretary

Robert J. Bedmarek
Treasurer

Staff
Melissa G. Ford
Executive Director

Laurie Paul
Associate Director

Victoria Kearns
Manager, Admin. Services

Richard D. Weedman
National Health Care Consultant

Frederick H. Grassle, Esq.
General Counsel
Perley, Kumble & Wagner
Washington, D.C.

NATIONAL ASSOCIATION OF
ALCOHOLISM TREATMENT PROGRAMS, INC.

January 28, 1986

Jodi:

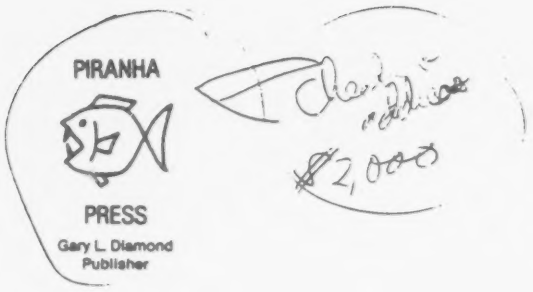
The names that are checked off are those who will be in attendance at the luncheon with Senator Durenberger. To this list, please add, Ed Carels, Comprehensive Care Corp., Irvine, California.

Regards,

Fred

2082 Michelson Drive • Suite 304 • Irvine, CA 92715 • (714) 476-8204

G



March 12, 1986

Mr. Frederick H. Graefe
Finley, Kumble, Wagner, Heine,
Underberg, Manley & Casey
1140 Connecticut Avenue NW
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Graefe:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Association of Alcoholism Treatment Programs, Inc. on February 5, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711 H

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

I

APPEARANCE SCHEDULE

Date	Place	Amount
February 5, 1986	Washington, DC	$2,000

NATIONAL ASSOCIATION
OF ALCOHOLISM TREATMENT
2010 MICHELSON, STE. 200
IRVINE, CA 92715

8100

April 3, 86

Piranha Press 2,000.00

Two-Thousand and----------00/100

SECURITY PACIFIC NATIONAL BANK
[illegible]

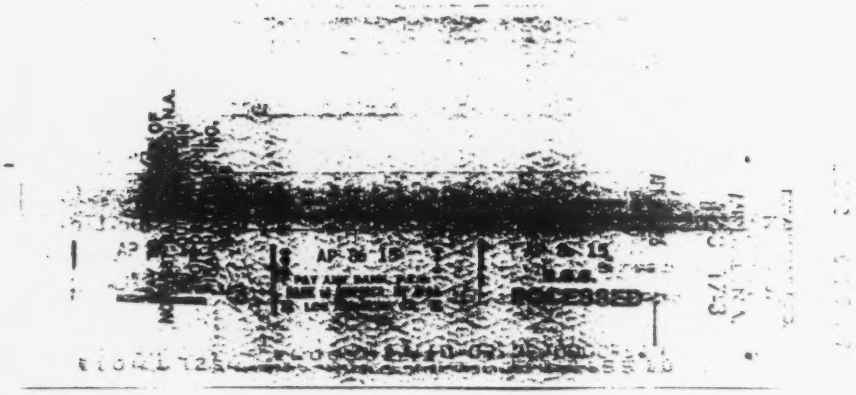
NOT NEGOTIABLE

NATIONAL ASSOCIATION
OF ALCOHOLISM TREATMENT
2010 MICHELSON, STE. 200, IRVINE, CA

DELUXE FORM 8103-3 V-3

		AMOUNT	
4/3/86	promotional appearance by Senator Durenberger on Feb. 5, 1986	$2,000.00	636

K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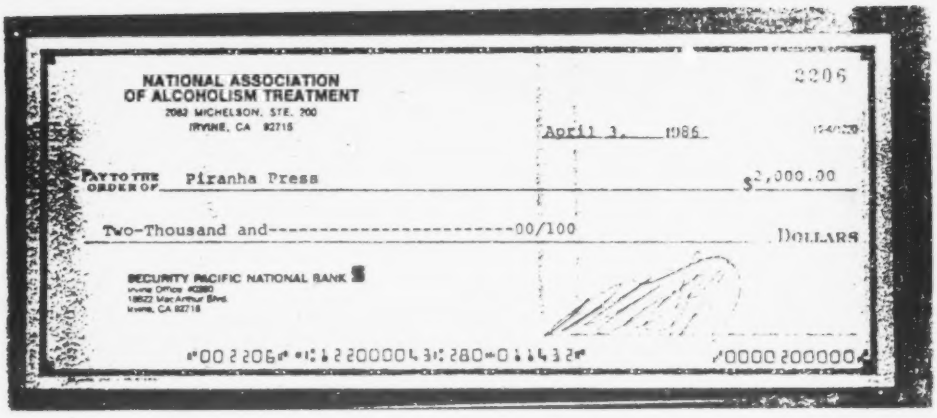

NATIONAL ASSOCIATION
OF ALCOHOLISM TREATMENT
2082 MICHELSON, STE. 200
IRVINE, CA 92715

2206

April 3, 1986

PAY TO THE ORDER OF Piranha Press $2,000.00

Two-Thousand and----------00/100 DOLLARS

SECURITY PACIFIC NATIONAL BANK
Irvine Office #0380
18622 Mac Arthur Blvd.
Irvine, CA 92715

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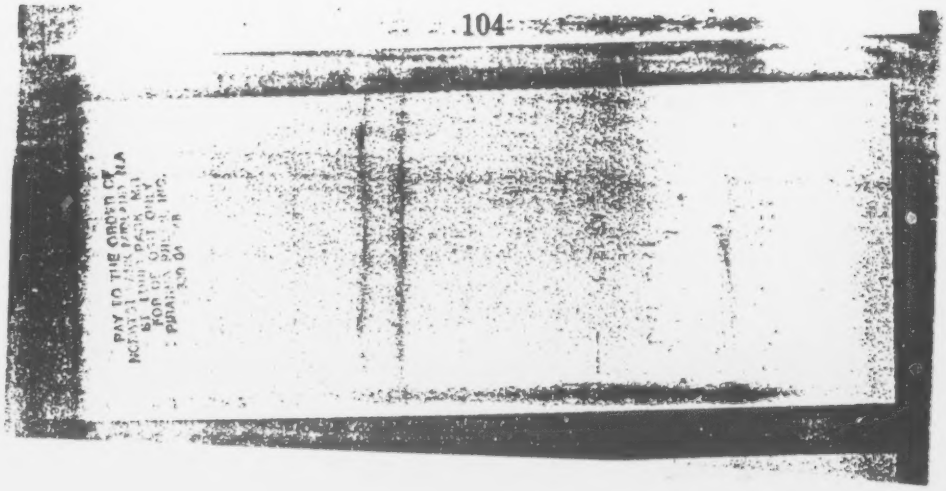

PAY TO THE ORDER OF

To: Mahoney/Tamara
From: Jodi/DD

KING & SPALDING
1730 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20006-4706
202/737-0500
TELECOPIER 202/737-5714
2500 TRUST COMPANY TOWER
ATLANTA, GEORGIA 30303
404/572-4600

~12:30 best time

1. Date of event 3/4/86
2. time of event is pending
3. $2K
4. they are expecting Mikes call - Jodie

O.K.'d 2/25/86
telecopied 2/25/86

February 19, 1986

Ms. Margaret Wrightson
Committee on Governmental Affairs
United States Senate
Hart Building, Room 432
Washington, D.C. 20510

- 12:30 Remarks -
1.15 end

OK (P.P.)

Dear Margaret:

This will confirm our conversation yesterday in which I invited both you and Senator Durenberger to speak to the Legislative Conference of the National Association of Bond Lawyers on either Tuesday or Wednesday, March 4 or 5, at the Hyatt Regency on Capitol Hill. Over 250 bond lawyers from throughout the United States have registered to attend the conference, and their primary interest will be the Senate consideration of the bond provisions of H.R. 3838. Based on our conversations regarding Senator Durenberger's alternative bond package, I am confident that bond lawyers will rally behind that proposal once they understand it.

Room -

250 - 1/2

While bond lawyers represent a special interest that is viewed with skepticism on the Hill, the very nature of their practice gives them substantial day-to-day contact with state and local government officials. We will make a strong effort at the legislative conference to direct the efforts of bond lawyers toward promoting state and local government lobbying with their respective Washington delegations. In any event, I am convinced that the participants in NABL's Legislative Conference could be substantial allies to Senator Durenberger.

Ideally, Senator Durenberger will make a brief address at our luncheon on March 4, and you will either precede or follow him with greater specificity. If the luncheon is at an inconvenient time for him, we would welcome his joining us at his convenience during the course of the program which will run from 9:00 to 4:00 on Tuesday, and from 9:00 to 12:00 on Wednesday. Obviously, our flexibility also applies to your schedule. If you wind up soloing and your schedule permits, I would prefer that you speak Wednesday morning. A number of the participants have appointments on the Hill Wednesday afternoon, and I would like for

SPECIAL
COUNSEL
HEARING
EX. 163
A

them to have been focused recently on the Durenberger proposal. As I indicated, unless Senator Durenberger is uncomfortable receiving an honorarium from the group, we certainly consider one to be appropriate. $2K

Please give me a call with any questions, and let me know at your earliest convenience if one or both of you will be able to join us.

Thank you for all of your efforts.

Sincerely,

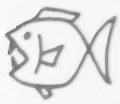
Theodore M. Hester

/dj

cc: James W. Perkins, Esq.

B

PIRANHA



PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Mr. Theodore M. Hester
King & Spalding
1730 Pennsylvania Avenue NW
Washington, DC 20006-4706

FROM: PIRANHA PRESS

DATE: FEBRUARY 26, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

We wish to advise you that Senator Durenberger has entered into an exclusive arrangement with us under which we must consent to his appearance and agree to the fees and expenses for any such appearance. Under our arrangement, you will be contacted by the law firm which represents Senator Durenberger for purposes of clarifying this arrangement and the fees to be paid.

If you have any questions, please contact Senator Durenberger's office or Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.
Kitty Gamble
Jodi Mathison

4504 EXCELSIOR BLVD. - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

ATTACHMENT C

KING & SPALDING
1730 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20006-4706
202/737-0500

TELECOPIER: 202/737-5714

2500 TRUST COMPANY TOWER
ATLANTA, GEORGIA 30303
404/572-4600

March 3, 1986

The Honorable David Durenberger
United States Senate
Washington, D.C. 20510

Attention: Ms. Jodi Mathison

Dear Senator Durenberger:

We look forward to having you speak tomorrow at the Legislative Conference of the National Association of Bond Lawyers. We will begin our luncheon at 12:00, and hope you will join us for lunch if your schedule permits. In any event, I anticipate that you will be available to address the group starting sometime between 12:30 and 12:45. Our afternoon session does not begin until 2:00. The luncheon will be held in the Yorktown Room on the Ballroom Level of the Hyatt Regency on Capitol Hill.

The attached agenda of the Legislative Conference will give you an idea of the issues that will be discussed. Obviously, the Conference will be devoted to the impact of tax reform efforts on tax-exempt bonds. Since you are deeply involved with that subject, we are particularly pleased that you have agreed to join us. Over 250 bond lawyers from across the country have registered to attend. The three advanced registrants from Minnesota are Trudy Halla and Tony Stemberger of Briggs & Morgan, and Robert Toftey, of the Fryberger, Buchanan firm in Deluth. I have asked Trudy Halla to introduce you. In addition to being from Minnesota, she is Treasurer of NABL.

I received a note from Piranha Press with respect to your speaking engagement, and will coordinate with Michael Mahoney.

We look forward to having you with us. Please give me a call if you have any questions.

Sincerely,

Theodore M. Hester

cc: Ms. Margaret Wrightson
Ms. Trudy Halla

D

CURTIN, MAHONEY & CAIRNS
A Professional Association
Attorneys at Law
4150 Multifoods Tower
Minneapolis City Center
Minneapolis, Minnesota 55402
(612) 333-5411

TELECOPIER COVER LETTER

PLEASE DELIVER THE FOLLOWING PAGES

TO: NAME: Theodore M. Hester

ADDRESS: 1730 Pennsylvania Avenue NW

TELEPHONE: 272-737-0500 telecopy: 202-737-5714

FROM: NAME: Michael C. Mahoney

ADDRESS: above

TELEPHONE: 612-333-5411

DATE: March 3, 1986 TIME: 124

SPECIAL INSTRUCTIONS: Attached is a form of agreement that normally is sent out from Piranha Press regarding its agreement with Senator Durenberger. In view of the time constraint, we are telecopying it to you. Please contact Michael Mahoney to formalize terms.

TOTAL NO. OF PAGES INCLUDING THIS COVER LETTER: 4

WE ARE TRANSMITTING ON THE FOLLOWING SPEED:

2 ____, 3 ____, 4 ____, 6____ (Min.)

IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL OUR OFFICE AT (612) 333-5411 AS SOON AS POSSIBLE. ~~THANK YOU.~~

Telecopier Phone: (612) 339-6962

C, M & C Operator: TKSteele

Our File Name: D.D. —

Our File Number: _____

E

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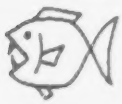


PRESS

Gary L. Diamond
Publisher

March 5, 1986

Mr. Theodore M. Hester
King & Spalding
1730 Pennsylvania Avenue NW
Washington, DC 20006

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Hester:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Association of Bond Lawyers on March 4, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCEL[illegible]/D. - MINNEAPOLIS, MINN. 55418 PHONE (612) 920-7711

F

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
March 4, 1986	12:30 p.m.	Hyatt Regency Hotel Washington, D.C.	$ 2,000

3/3/86

Theodore M. Hester,
Conference Chairman
National Association of Bond Lawyers
1986 Legislative Conference

H

NATIONAL ASSOCIATION of BOND LAWYERS
Post Office Box 197 • Hinsdale, Illinois 60521 • (312) 920-0160

1986 LEGISLATIVE CONFERENCE
NATIONAL ASSOCIATION OF BOND LAWYERS
March 4-5, 1986
Hyatt Regency Hotel
Washington, D.C.

AGENDA

Tuesday Morning, March 4, 1986
Columbia B - Ballroom Level

8:00-9:00 a.m. Registration; distribution of materials; coffee and donuts.

9:00-9:10 a.m. Welcome and introductory comments. Theodore M. Hester, King & Spalding, Washington, D.C., Conference Chairman.

9:10-10:20 a.m. H.R. 3838 - Its Impact on Tax-Exempt Bonds. Panel discussion led by Charles L. Almond, Vinson & Elkins, Washington, D.C., with the following participants:

Thomas S. Currier (Dewey, Ballantine, Bushby, Palmer & Wood, New York, New York)

William M. Loafman (Finley, Kumble, Wagner, Heine, Underberg, Manley & Casey, Washington, D.C.)

Lynd K. Mische (Stunson, Mag & Fizzell, Kansas City, Missouri)

10:20-10:30 a.m. Break

10:30-11:00 a.m. Continuation of H.R. 3838 Panel

11:00-11:50 a.m. Bond Reform: perspective from the Ways and Means Tax Staff. Bruce F. Davie, Tax Staff, Committee on Ways and Means, United States House of Representatives. Remarks on tax reform, and questions and answers.

Luncheon - 12:00
Yorktown Room - Ballroom Level

Speaker: The Honorable David Durenberger, Minnesota

Senator Durenberger will be accompanied by Margaret Wrightson, Staff Director of the Subcommittee on Intergovernmental Relations of the Senate Governmental Affairs Committee. Trudy J. Halla, Briggs & Morgan, St. Paul, Minnesota, will introduce Senator Durenberger.

Tuesday Afternoon
Columbia B - Ballroom Level

2:00-2:15 p.m. Impact of Tax Reform on Infrastructure Financing. S. Frank D'Ercole, Robinson & Cole, Hartford, Connecticut. Frank D'Ercole is a member of the Private Sector Advisory Panel on Infrastructure Financing, Advisory to the U.S. Senate Committee on the Budget, Senator Pete V. Domenici, Chairman.

2:15-4:00 p.m. Bond Reform: Legislative Strategies. Panel Discussion led by Paul R. Schilling of Mulcahy & Wherry, S.C., Milwaukee, Wisconsin, with the following participants:

Richard Geltman, General Counsel, National Governors' Association
Heather Ruth, Executive Director, Public Securities Association
Frank Shafroth, Director of Federal Relations, National League of Cities
Catherine L. Spain, Director, Federal Liaison Center, Government Finance Officers Association
Samuel C. Stone, Stone Jessup, P.C., Tulsa, Oklahoma

Congressional Reception, 5:00 - 7:00 p.m.
Rayburn House Office Building
Gold Room, Room 2168

Wednesday, March 5, 1986
Regency A - Ballroom Level

9:00-10:15 a.m.	Bond Reform: Tax Staff Perspective from the Senate Finance Committee, the Joint Tax Committee and the Department of Treasury. Remarks, discussion, and questions and answers from the following panelists: H. Ben Hartley, Joint Committee on Taxation Randy Hardock, Minority Tax Staff, Senate Finance Committee Elliot Stern, Office of Tax Legislative Counsel, United States Department of Treasury
10:15-10:30 a.m.	Break
10:30-12:00 a.m.	Summation, consideration of issues identified by audience as meriting further comment, and a discussion of NABL's Legislative Activities by the following panelists: James M. Perkins, President of NABL, Palmer & Dodge, Boston, Massachusetts. Theodore M. Hester, Chairman, NABL Legislative Action Committee. Amy Dunbar, Palmer & Dodge. Amy Dunbar is currently working full time with Ted Hester in King & Spalding's Washington Office coordinating NABL's legislative activity.

KING & SPALDING
1730 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20006-4706
202/737-0500

TELECOPIER: 202/737-5714

2500 TRUST COMPANY TOWER
ATLANTA, GEORGIA 30303
404/572-4600

March 17, 1986

The Honorable David Durenberger
United States Senate
Washington, DC 20510

Dear Senator Durenberger:

Thank you for taking the time to speak to the National Association of Bond Lawyers during the Legislative Conference last week. This group will have front-line contact with any bond legislation that is ultimately enacted, and your presentation at the Conference was both thorough and timely. You and Margaret left the audience with the distinct impression that you are light-years ahead of the Finance Committee in handling bond reform responsibly.

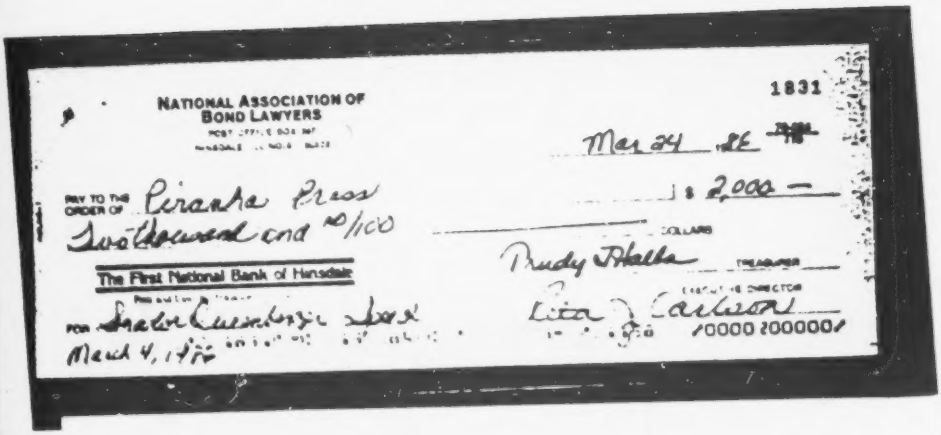
Thanks for all your hard work. Call on us when we can be helpful.

Sincerely,

Theodore M. Hester

cc: Margaret Wrightson
James W. Perkins
Amy K. Dunbar

L



NATIONAL ASSOCIATION OF
BOND LAWYERS

1831

Mar 24 82

PAY TO THE ORDER OF Piranha Press

$ 2,000 —

Two thousand and no/100 DOLLARS

The First National Bank of Hinsdale

Rudy Hlella

EXECUTIVE DIRECTOR

FOR Shadow Cumbrae Book

Lita Carlson

March 4, 1982

10000 200000

M

PAY TO THE ORDER OF

☐ VOID ☐ CORRECTED

PAYER'S name, street address, city, state, and ZIP code	1 Rents	OMB No 1545-0115	Miscellaneous Income
National Association of Bond Lawyers P.O. Box 397 Hinsdale, IL 60522	2 Royalties	1986 Statement for Recipients of	
PAYER'S Federal identification number: 36-3015503 / RECIPIENT'S identification number: 41-0989119	3 Prizes and awards	4 Federal income tax withheld	Copy C For Payer
RECIPIENT'S name (first, middle, last): Frances Lopez Senator Lucas Vega	5 Fishing boat proceeds	6 Medical and health care payments	For Paperwork Reduction Act Notice and instructions for completing this form, see Instructions for Forms 1099, 1098, 5498, 1096 and W-2G.
Street address: 4304 Excelsior Boulevard	7 Nonemployee compensation: 2,000.00	8 Substitute payments in lieu of dividends or interest	
City, state, and ZIP code: Minneapolis, MN 55416	9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐		
Account number (optional)			

Form 1099-MISC — Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED

PAYER'S name, street address, city, state, and ZIP code	1 Rents	OMB No 1545-0115	Miscellaneous Income
National Association of Bond Lawyers P.O. Box 397 Hinsdale, IL 60522	2 Royalties: 11,432.00	1986 Statement for Recipients of	
PAYER'S Federal identification number: 36-3015503 / RECIPIENT'S identification number: 94-2698987	3 Prizes and awards	4 Federal income tax withheld	Copy C For Payer
RECIPIENT'S name (first, middle, last): Jones Hall Hill & White	5 Fishing boat proceeds	6 Medical and health care payments	For Paperwork Reduction Act Notice and instructions for completing this form, see Instructions for Forms 1099, 1098, 5498, 1096 and W-2G.
Street address: Four Embarcadero Center	7 Nonemployee compensation	8 Substitute payments in lieu of dividends or interest	
City, state, and ZIP code: San Francisco, CA 94111	9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐		
Account number (optional)			

Form 1099-MISC — Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED

PAYER'S name, street address, city, state, and ZIP code	1 Rents	OMB No 1545-0115	Miscellaneous Income
National Association of Bond Lawyers P.O. Box 397 Hinsdale, IL 60522	2 Royalties: 5,711.85	1986 Statement for Recipients of	
PAYER'S Federal identification number: 36-3015503 / RECIPIENT'S identification number: 36-2894523	3 Prizes and awards	4 Federal income tax withheld	Copy C For Payer
RECIPIENT'S name (first, middle, last): Bond Case Briefs	5 Fishing boat proceeds	6 Medical and health care payments	For Paperwork Reduction Act Notice and instructions for completing this form, see Instructions for Forms 1099, 1098, 5498, 1096 and W-2G.
Street address: P. O. Box 397	7 Nonemployee compensation	8 Substitute payments in lieu of dividends or interest	
City, state, and ZIP code: Hinsdale, IL 60522	9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐		
Account number (optional)			

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1101 FOURTEENTH STREET, N.W.
WASHINGTON, D.C. 20005
(202) 682-7000
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NEW YORK, N.Y. 10153
(212) 310-8000
TELECOPIER (212) 752-3976
(212) 758-0173
CABLE WEISOMA
TELEX ITT 42428
ITT 423144

FLORIDA OFFICE
800 BRICKELL AVENUE
MIAMI, FLORIDA 33131
(305) 579-9500
TELECOPIER (305) 374-7159

ROBERT C. ODLE, JR.
COUNSEL
DIRECT LINE (202) 682-7180

April 26-28
Florida

March 13, 1985

Honorable Dave Durenberger
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

Anne Kelly and I have been discussing the possibility of your being with a client of our firm over the weekend of April 26-28. Our client, the National Association of Chain Drug Stores, headquartered in Alexandria, is having its annual meeting that weekend at the Breakers Hotel in Palm Beach, Florida, at which 200 top officials of drug stores from throughout the country will join together to discuss issues of concern to them in the 99th Congress.

As I've mentioned to Anne, we'd like you to speak on Sunday morning, April 28 (on whatever topic you like), or if that time is not convenient, at some other point during the weekend or even on Monday morning. Naturally, round-[redacted] be provided for you, Mrs. Durenberger and/or a member of your staff, as well as rooms at the Breakers. The Association also would provide an [redacted]

It would be an easy trip. There is nonstop service between Washington and Palm Beach, and the Breakers is a grand old hotel only twenty minutes from the airport. You would, of course, be welcome to stay through the weekend if you wished. Although I am new to the firm and to the client, having left my position as Assistant Secretary of Energy

SPECIAL COUNSEL HEARING EX. 164

Pfizer speech is Sunday am in Miami.

A

WEIL, GOTSHAL & MANGES

Kitty 3/3

just a few weeks ago, I do know the Breakers and Palm Beach well, and would personally make certain that you had a pleasant and comfortable stay.

If you or Anne have any questions, please do not hesitate to call. We hope very much to have you with us.

With best wishes,

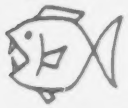
Sincerely,

Rob Odle

Robert C. Odle, Jr.

B

PIRANHA
122



PRESS

Gary L. Diamond
Publisher

March 29, 1985

Robert C. Odle, Jr., Esq.
Weil, Gotshal & Manges
1101 14th Street N.W.
Washington, D.C. 20005

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Odle:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Association of Chain Drug Stores in the near future.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book, Neither Madmen Nor Messiahs, and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book. It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

Because Senator Durenberger's appearance before your organization will be in promotion of Neither Madmen Nor Messiahs, we expect that you will make available to us adequate space at or near the

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

D

PROMOTIONAL APPEARANCE FOR
NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Date	Place	Amount
Sunday, April 28	Palm Beach, Florida	$5,000

E

WEIL, GOTSHAL & MANGES
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
1101 FOURTEENTH STREET, N. W.
WASHINGTON, D. C. 20005

(202) 682-7000
N. Y. TIE-LINE (212) 431-8820
TELECOPIER (202) 289-7502
(202) 789-0094
TELEX ITT 440045

NEW YORK OFFICE
767 FIFTH AVENUE
NEW YORK, N. Y. 10153
(212) 310-8000
TELECOPIER (212) 752-1978
(212) 758-3273
CABLE WEGOMA
TELEX ITT 424281
ITT 423144

FLORIDA OFFICE
800 BRICKELL AVENUE
MIAMI, FLORIDA 33131
(305) 579-9500
TELECOPIER (305) 374-7159

ROBERT C. ODLE, JR.
COUNSEL
DIRECT LINE (202) 682-7180

March 29, 1985

James A. Whitman, Esquire
Chief Counsel
National Association of Chain Drug Stores
413 North Lee Street
Alexandria, Virginia 22314

Dear Jim:

Well, all's well that ends well and I think the appearance by Senator Durenberger is ending well.

First, after we talked, Anne Kelly called back and found a private plane to take him to Miami from West Palm after your Sunday breakfast. As we discussed, the Association will need to purchase for him a first class ticket on Eastern #889 leaving Washington at 7:55 p.m. and arriving West Palm at 9:56 p.m. on Thursday, April 25. There will be no other travel costs to the Association, and the Senator will be with you from Thursday evening through Sunday morning.

The check for $5000 should be sent to Piranha Press, Inc., 4504 Excelsior Boulevard, Minneapolis 55416. And Anne called again to thank you and me for the flowers, so things do seem to be in shape.

Sincerely,

Robert C. Odle, Jr.

F

NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC.
P.O. BOX 1417-D49
ALEXANDRIA, VA 22313

NATIONAL UNITED VIRGINIA BANK
ALEXANDRIA-MANASSAS-ARLINGTON
FAIRFAX-PRINCE WILLIAM, VIRGINIA

CHECK 00[illegible]

56-107/56

DATE 4/29/85

PAY THIS AMOUNT ********5,000 DOLLARS .00 CENTS

AMOUNT OF CHECK ********5,000.[illegible]

TO THE ORDER OF PIRANHA PRESS

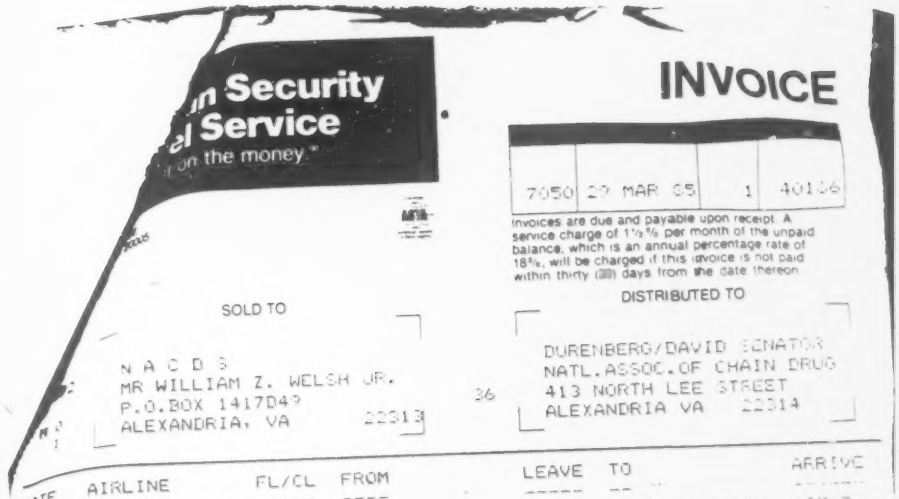
000897
004892
71

William J. Walsh, Jr.

"000489 2" :056001079": 055 68 369" "0000500[illegible]

G

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
320 04 348



n Security
l Service
on the money.

INVOICE

7050	27 MAR 85	1	40106

Invoices are due and payable upon receipt. A service charge of 1½% per month of the unpaid balance, which is an annual percentage rate of 18%, will be charged if this invoice is not paid within thirty (30) days from the date thereon.

SOLD TO

N A C D S
MR WILLIAM Z. WELSH JR.
P.O.BOX 1417D49
ALEXANDRIA, VA 22313

DISTRIBUTED TO

DURENBERG/DAVID SENATOR
NATL.ASSOC.OF CHAIN DRUG
413 NORTH LEE STREET
ALEXANDRIA VA 22314

DATE	AIRLINE	FL/CL	FROM	LEAVE	TO	ARRIVE
25APR THU	EASTERN	0809F	WASH/NATIONAL	0755P SNACK	WEST PALM BCH	0950P

THIS INVOICE REPRESENTS A SAVINGS OF $195.00 PER PASSENGER AS COMPARED TO THE NORMAL Y FARE.

DURENBERG/DAVID SENATOR TKT # 0077579670324 $ 265.00

78300

TOTAL $ 265.00

I

This receipt is issued by American Security Travel Service in the capacity of your agent in all matters pertaining to reservations and travel ar on the express condition that we shall not be responsible, directly or indirectly for loss, accident, injury, delay, defect, omission or irregular which may occur or be occasioned, whether by reason of an act, negligence or default of any company or person engaged in or responsib for carrying out the arrangements, or otherwise in connection therewith.

PAGE 1 [redacted] GROUP DELEGATE/CONVENTION
4/29/85 IN HOUSE GROUP

THE BREAKERS

Palm Beach, Florida 33480

ROOM
ARRIVE 4/22/85
DEPART 5/08/85
PERSONS 1

RES ID 310340375528
FOL ID 311411277880

MICHAEL DOLAN
PO BOX 1417-D49

ALEXANDRIA VA 22314

GROUP NACD85 NATL ASSOC CHAIN DRUG STR
TRANSFER FROM DAVID F DURENBERGER 311381114584

PLEASE RETURN THIS TOP PORTION WITH YOUR REMITTANCE

DATE	REFERENCE	S	DESCRIPTION	AMOUNT
4/25/85	311419000104		ROOM CHARGE 3107	121.50
			TAX	8.28
4/24/85	311429000189		ROOM CHARGE 3107	118.50
			TAX	8.13
4/27/85	311439000211		ROOM CHARGE 3107	118.50
			TAX	8.13
4/27/85	311431285730		00001 LOCAL CALLS	.75
	422-3084			
			4223084 04/27 08:56	
4/27/85	311431286101		ROOM SERVICE FOOD	9.44
4/27/85	311431292671		00001 LOCAL CALLS	.75
	422-3084			
			4223084 04/27 23:48	
4/28/85	311441293981		ROOM SERVICE FOOD	12.47
4/29/85	311451301379		GROUP SETTLEMENT	402.48-
	310340375528		MICHAEL DOLAN	

CHARGES INCURRED ON YOUR DAY OF DEPARTURE MAY NOT BE REFLECTED ON THIS STATEMENT. AN INVOICE WILL BE MAILED TO YOU FOR SUCH DAY OF DEPARTURE CHARGES.

TOTAL 0.00

GUEST SIGNATURE _____

BILL TO COMPANY _____

ALL AMOUNTS CHARGES ARE DUE UPON PRESENTATION OF YOUR BILL. FAILURE TO PAY FOR 30 DAYS AFTER THE DUE DATE WILL RESULT IN THE IMPOSITION OF A FINANCE CHARGE. THE FINANCE CHARGE WILL BE APPLIED TO THE PORTION OF THE PREVIOUS BALANCE WHICH THAN 30 DAYS OLD AND WILL BE COMPUTED AT THE RATE OF 1½% PER MONTH. THIS IS AN ANNUAL PERCENTAGE RATE OF 18%. ALL PAYMENTS AND CREDITS ARE DEDUCTED FROM THE PREVIOUS BALANCE PRIOR TO THE COMPUTATION OF THE FINANCE CHARGE.

December 11, 1985

Dave Durenberger
Senator State of Minnesota
United States Senate
Washington, DC 20510

Dear Senator Durenberger:

As President of The National Association of Container Distributors, I would like to invite you to speak to our annual Convention.

We are having our Convention at the Mayflower Hotel in Washington, DC from April 16, 1986 through April 19, 1986.

I would like you to address us at our luncheon either Thursday, April 17, 1986 or Friday, April 18, 1986.

Your appointment secretary Jodi Mathison advised your schedule for the spring is not set yet so an early reply will be appreciated.

Thanking your for your consideration, I remain,

Yours truly,

John F. Slater
President - NACD

JFS:nmv

SPECIAL
COUNSEL
HEARING
EX. 165

A

4/17 to

NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS
the national voice of wholesale distribution

1725 K Street, N.W.
Washington, D.C. 20006
202/872-0885
Nicholas E. Calio
Vice President - Government Relations
Direct Dial 202/728-7660

February 12, 1986

To: Mahoney/Tamara
FROM: JODI/DD

The Honorable David Durenberger
United States Senate
375 Russell Senate Office Bldg.
Washington, D.C. 20510

agreed to 3/4/86
telecopied 3/5/86

Contact: John Slater
612-331-3330
#2K is O.K.

Dear Dave:

I have just seen a copy of John Slater's December 11 letter inviting you to speak to the National Association of Container Distributors Annual Convention here in town on either April 17 or 18.

I hope you will have the opportunity to meet with the group.

NACD is one of NAW's most valuable member associations, both in terms of general government relations and the Wholesaler-Distributor Political Action Committee.

I hope all else is well and that we'll have the opportunity to talk soon. In the meantime, Dave, best regards.

Sincerely,

Nick

Nicholas E. Calio
Vice President - Government Relations

cc: Jerome Rosenstone
John Slater

Mayflower
Room 578

#2K honorarium O.K.
Thurs April 17th
12:00 noon @ Mayflower
- send letter to John Slater confirming the event

4/14/86
DD can arrive at 1:30 they will begin eating @ 12:15
People 178

8:15 State Room
lobby ☆ left
→ Colonial Lower LL out in

Slater
President NACD
% Twin City Bottle Co.
1227 East Hennepin Ave
Mpls., MN 55414

PIRANHA

PRESS

Gary L. Diamond
Publisher

March 12, 1986

Mr. John Slater
President NACD
Twin City Bottle Co.
1227 East Hennepin Avenue
Minneapolis, MN 55414

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Slater:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Association of Container Distributors Annual Convention on April 17, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

Mr. John Slater
President NACD
Twin City Bottle Co.
March 12, 1986
Page 2

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

D

APPEARANCE SCHEDULE

Date	Place	Amount
April 17, 1986	Washington, DC	$2,000

E

DAVE DURENBERGER
MINNESOTA

United States Senate

WASHINGTON, D.C. 20510

March 12, 1986

Mr. John Slater
President
National Association of
Container Distributors
c/o Twin City Bottle Company
1227 East Hennepin Avenue
Minneapolis, Minnesota 55414

Dear Mr. Slater:

This letter is to confirm Senator Durenberger's remarks to the National Association of Container Distributors Annual Convention in Washington, D.C. on April 17, 1986 at the Mayflower Hotel.

It is my understanding that the Senator will speak to your group at 12:00 noon on April 17th for a stipend of $2000.00 per our conversation of last week. As we discussed the check should be sent to Pirahna Press at the following address:

4504 Excelsior Blvd.
Minneapolis, MN 55416

I am glad we were able to work things out and I will keep in contact with you regarding the details of the event.

Sincerely,

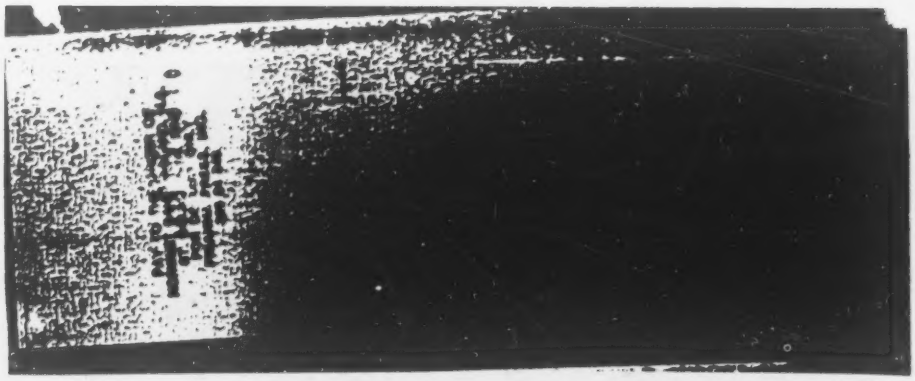
Jodi L. Mathison

Jodi L. Mathison
Office of Senator Dave Durenberger

/jlm

F

NATIONAL ASSOCIATION OF
CONTAINER DISTRIBUTORS
Central Trust



H

THE REGULATORS AND YOU

Presented by

The National Real Estate Investment Forum

Friday, April 19, 1985

The Hyatt Regency Hotel

Columbia Rooms

400 New Jersey Avenue, N.W.

Washington, D.C

[redacted]

SPECIAL
COUNSEL
HEARING
EX. 166

A

Hear experts from the U.S. Treasury, Senate Committee on Finance, IRS, SEC, NASD, Federal Reserve Board, Department of Labor and private industry discuss current regulation and legislation impacting your business.

Lunch with staff representatives of the NASD and SEC and discuss your personal industry views and concerns.

PROGRAM:

8:30 a.m. - 8:35 a.m.

INTRODUCTION

Robert J. Walner, SRS, Program Chairman
First Vice President and General Counsel
Balcor/American Express Inc.

8:35 a.m. - 10:45 a.m.

FEDERAL TAXATION PANEL

"WILL REAL ESTATE SURVIVE?

A Discussion Of:

NEW TAX LEGISLATION
- 35 + Partnerships
- Interest Deductions
- Depreciation
- At Risk
- OID
- Other Developments

Moderators:

Richard A. Hanson, SRS
President
Stein & Co.

Jeffrey C. Rubenstein, SRS
Principal
Sachnoff, Weaver & Rubenstein, Ltd.

Panelists:

Mark A. Kuller
Special Assistant to the Chief Counsel
Internal Revenue Service

Anne Moran
Tax Counsel
Senate Committee on Finance

Mikel M. Rollyson
Tax Legislative Counsel
Department of the Treasury

11:00 a.m. - 11:45 a.m.

ERISA PANEL

A Discussion Of:

DEPARTMENT OF LABOR 1985 PROPOSED PLAN ASSET REGULATIONS

Moderator:

Robert J. Walner, SRS
First Vice President and General Counsel
Balcor/American Express Inc.

Panelists:

Peter M. Kelly
Partner
Bell, Boyd & Lloyd

Donald J. Myers
Of Counsel
Pierson, Ball & Dowd

A high-ranking representative from the Department of Labor will also participate.

11:45 a.m. - 1:30 p.m.

NATIONAL REAL ESTATE INVESTMENT FORUM LUNCHEON

Keynote Speaker:

Senator Bob Packwood (R., Oregon)
Chairman, Senate Committee on Finance

Staff members of the SEC and the NASD will be seated at each table offering attendees an opportunity to discuss area of particular concern.

1:30 p.m. - 2:30 p.m.

SECURITIES AND EXCHANGE COMMISSION NATIONAL ASSOCIATION OF SECURITIES DEALERS, INC. PANEL

A Discussion Of:

CURRENT DEVELOPMENTS IN REGULATION D

OTHER DEVELOPMENTS

USE OF ADVERTISING IN CONNECTION WITH PRIVATE AND PUBLIC SYNDICATIONS; SEC RULE 134

GENERIC ADVERTISING

Moderators:

Warren F. Grienenberger
Senior Partner
Gardner, Carton & Douglas

Donald L. Silverman, SRS
Vice President/Assistant General Counsel
Consolidated Capital Companies

Panelists:

Irving D. Borochoff
Assistant Director
Division of Corporation Finance
Securities and Exchange Commission

R. Clark Hooper
Director of Advertising
Division of Advertising
National Association of Securities Dealers, Inc.

John R. Larson, SRS
Partner
Holmes & Graven, Chartered

William Morley
Chief Counsel
Division of Corporation Finance
Securities and Exchange Commission

2:30 p.m. - 3:15 p.m.

SECURITIES AND EXCHANGE COMMISSION, FEDERAL RESERVE BOARD, NATIONAL ASSOCIATION OF SECURITIES DEALERS, INC. PANEL

A Discussion Of:

RECENT DEVELOPMENTS UNDER REGULATION T
Installment Payments By Investors In Limited Partnership Offerings

SALES MADE BY EMPLOYEES OF ISSUERS

USE AND HANDLING OF OFFERING PROCEEDS IN BEST EFFORTS DISTRIBUTIONS: SEC RULE 15c2-4

Moderator:

Robert J. Walner, SRS
First Vice President and General Counsel
Balcor/American Express Inc.

Panelists:

Larry E. Bergmann
Assistant Director
Division of Market Regulation
Securities and Exchange Commission

Mary E. Chamberlin
Chief Counsel
Division of Market Regulation
Securities and Exchange Commission

Laura M. Homer
Securities Credit Officer
Federal Reserve Board

Suzanne E. Rothwell
Assistant Director
Division of Corporate Financing
National Association of Securities Dealers, Inc.

3:30 p.m. - 4:45 p.m.

NATIONAL ASSOCIATION OF SECURITIES DEALERS, INC. PANEL

A Discussion Of:

APPENDIX F
Sales Awards
Problems in Meeting Organization and Offering Expense Limits—The 10% and 15% Rules

THE SECONDARY TRADING MARKET

LICENSING—REITs

Moderator:

Michael F. Cornicelli
Senior Counsel
IMB Realty Corporation

Panelists:

Richard I. Fortwengler
Senior Analyst
Division of Corporate Financing
National Association of Securities Dealers, Inc.

Frank J. McAuliffe
Vice President
Division of Qualifications
National Association of Securities Dealers, Inc.

Suzanne E. Rothwell
Assistant Director
Division of Corporate Financing
National Association of Securities Dealers, Inc.

A COCKTAIL RECEPTION FOR ALL PROGRAM PARTICIPANTS AND REGISTRANTS WILL IMMEDIATELY FOLLOW.

Application has been made for CLE and CPE accreditation.

THE REGULATORS AND YOU

C

A Seminar for Professionals in Real Estate Securities and Taxation

REGISTRATION

Please enter _____ registrations for *The Regulators and You*, presented by the National Real Estate Investment Forum, on Friday, April 19, 1985 at the Hyatt Regency Hotel in Washington, D.C.

Name

Firm Name

Address

City/State/Zip Code

Telephone Number

Name

Firm Name

Address

City/State/Zip Code

Telephone Number

☐ Forum Member ($150 per person)
☐ RESSI® Member ($175 per person)
☐ Other ($225 per person)

Enclosed is my check, made payable to the National Real Estate Investment Forum, in the amount of $_____ which covers _____ registration(s) for *The Regulators and You*.

Or charge my credit card
(when paying by credit card, fill in the following)
_____ VISA _____ MasterCard

Card Number

Expiration Date

Return registration form, or a photocopy, marked **Personal & Confidential**, with your remittance to:

Lisa B. Johnson
National Real Estate Investment Forum
430 North Michigan Avenue
Chicago, Illinois 60611-4091
(312) 670-6760

Space is limited and all registrations are accepted in the order in which they are made. Participants are responsible for their hotel reservations.

☐ Please send me membership information on the REAL ESTATE SECURITIES AND SYNDICATION INSTITUTE® and the National Real Estate Investment Forum.

THE REAL ESTATE SECURITIES AND SYNDICATION INSTITUTE®
an affiliate of THE NATIONAL ASSOCIATION OF REALTORS®
430 North Michigan Avenue, Chicago, Illinois 60611-4091, (312) 670-6760

31-403 141 D

ADDENDUM

"The Regulators and You"

Due to unavoidable circumstances, Senator Bob Packwood has cancelled his speaking engagement at the National Real Estate Investment Forum luncheon on Friday. The keynote luncheon address will be delivered instead by Senator Dave Durenberger of Minnesota, a Republican member of the Senate Committee on Finance.

Senator Durenberger is the sponsor of Senate Bill 729, introduced on March 26, 1985, which would replace stop-gap imputed interest and original issue discount rules, set to expire on July 1, with a similar two-tiered imputed interest system.

E

NATIONAL ASSOCIATION OF REALTORS®

REALTOR®

CHECK REQUISITION

PAYABLE TO: Senator Dave Durenberger (202)224-3244 DATE: 4/23/85

ADDRESS: 375 Senate Russell Office Bldg CITY: Washington STATE: D.C. ZIP CODE: 20510

	ACCOUNT(S) CHARGED	AMOUNT
Speaker payment for keynote luncheon presentation at "The Regulators & You" on 4/19/85	19-580-041005	$2,000.00
	RECEIVED APR 25 ACCOUNTS PAYABLE	
75835	TOTAL	$2,000.00

REQUESTED BY: A. Johnson DEPARTMENT/AFFILIATE: RESSI APPROVED BY: Patrick Canton

168 03 1 (formerly 111-83) DISTRIBUTION: WHITE & CANARY – TO ACCOUNTING DEPT. • PINK – ORIGINATOR'S FILE COPY

REALTOR®

NATIONAL ASSOCIATION OF REALTORS® № 132426
CHICAGO, ILLINOIS

2-77
710

DATE	CHECK NO.	PAY TO THE ORDER OF	AMOUNT
APR2585	132426	SENATOR DAVE DURENBERGER	$2000.00 ■ $2000.00

GENERAL ACCOUNT

[redacted]NATIONAL BANK AND TRUST
[redacted]COMPANY OF CHICAGO

⑈132426⑈ ⑆071000770⑆ 00322679⑈ ⑈0000200000⑈

G

FOR DEPOSIT ONLY

TO THE ORDER OF
[redacted]
ST BANK MIDLAND, N.A.
ST LOUIS PARK, MN
FOR DEPOSIT ONLY
[redacted]
ANHA PRESS, INC.
320 04 346

5555 6 - - 01

17-3 17-4

MAY - 6 93

THE NATIONAL REAL ESTATE INVESTMENT FORUM
430 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60611-4091
(312) 670-6760

April 29, 1985

Mr. Gary Diamond
Piranha Press
4504 Excelsior Boulevard
Minneapolis, Minnesota 55416

Dear Mr. Diamond,

I have enclosed a check for $2,000 made payable to Senator Dave Durenberger as an honorium for his luncheon address at our program, "The Regulators and You," which was held on April 19, 1985 in Washington, D.C. Ann Kelly, a member of his staff, asked me to forward the check to you.

If you have any questions, please do not hesitate to contact me at the telephone number listed on the above letterhead. Thank you for your attention.

Very truly yours,

Lisa Johnson

Lisa B. Johnson
National Real Estate Investment Forum
Coordinator

Encl.

NATIONAL ASSOCIATION OF REALTORS® Nº 132426
CHICAGO, ILLINOIS
REALTOR®

DATE	CHECK NO.	PAY TO THE ORDER OF	2-77 710 AMOUNT	
APR2585	132426	SENATOR DAVE DURENBERGER	$2000.00 ■	$2000.00 ■

GENERAL ACCOUNT

AMERICAN NATIONAL BANK AND TRUST COMPANY OF CHICAGO

⑈132426⑈ ⑆071000770⑆ 00322679⑈

A DIVISION OF THE REAL ESTATE SECURITIES AND SYNDICATION INSTITUTE®

I

SCHEDULING INFORMATION

OKD

SPEECH — TYPE OF EVENT
9/25/86 noon — EVENT DATE/TIME

Natl Assoc of Senior Living Industries — GROUP NAME

SPEECHES
Group Size ~250
Honorarium 2K
(amount)

Contact Fred Graefe
Phone 659-8300
Key People

Topic Issues cutting across entire aging field

Room Set-Up
Introduction by
Taped ____ (y/n) Transcribed ____ (y/n)
Fred to meet @ noon
12:15 Lunch to be ser...

FOLLOW-UP
Thanks Sent 9/27/86 (date)
Photo ____ (y/n) Sent ____ (date)
Photo to Media (date)

Membership Lists
Received (y/n)
Computerized (y/n)
Filed (y/n)
Regret Sent
Greeting Sent (y/n)

LOCATION OF EVENT Washington DC
Place Mayflower Hotel
Room Colonial Room
Phone Number
Directions

STAFFING
Briefing Memo
Photo
Speech

MISCELLANEOUS
→ Breakfast → Pepper
Dinner → Dole

9/3/86
REQUEST DATE

SPECIAL COUNSEL HEARING EX. 167
A

FINLEY, KUMBLE, WAGNER, HEINE,
UNDERBERG, MANLEY, MYERSON & CASEY
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
1140 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
(202) 659-8300 TELEX 440346
CABLE VERITAS TELECOPIER (202) 466-7954

425 PARK AVENUE
NEW YORK, NEW YORK 10022
(212) 371-5900

9100 WILSHIRE BOULEVARD
BEVERLY HILLS, CALIFORNIA 90212
(213) 550-6100

101 WEST BROADWAY
SAN DIEGO, CALIFORNIA 92101
(619) 231-8700

777 BRICKELL AVENUE
MIAMI, FLORIDA 33131
(305) 371-2600

110 EAST BROWARD BOULEVARD
FT. LAUDERDALE, FLORIDA 33301
(305) 527-2000

707 WILSHIRE BOULEVARD
LOS ANGELES, CALIFORNIA 90017
(213) 612-3100

4400 MACARTHUR BOULEVARD
NEWPORT BEACH, CALIFORNIA 92660
(714) 851-2255

1140 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
(202) 857-4000

444 WORLD TRADE CENTER
401 EAST PRATT STREET
BALTIMORE, MARYLAND 21202
(301) 962-0215

LECONFIELD HOUSE
CURZON STREET, 5TH FLOOR
LONDON, W1Y 7FB, ENGLAND
(44) 499-4588

September 3, 1986

The Honorable Dave Durenberger
United States Senate
Washington, D.C. 20510

Dear Dave:

On behalf of the National Association of Senior Living Industries (NASLI), it is our pleasure to invite you to deliver the keynote address at the Association's Business Network Conference at the luncheon convocation on Thursday, September 25 at the Mayflower Hotel here in Washington.

NASLI is the newest and fastest growing association involved in aging issues. It was founded a year ago, at a meeting keynoted by the Honorable Claude Pepper, to meet a critical need in the field to bring the public and private sectors and profit and non-profit groups together into a single forum to address the needs of older Americans and the organizations that serve them. Among its members are the American Association of Retired Persons, the Harvard Medical School, health care providers such as the Hospital Corporation of America and Beverly Enterprises, and housing developers such as Marriott and Oxford Development Enterprises. We are enclosing a recent write-up of NASLI from the Aging Network News, which sets forth the enthusiastic response that NASLI has received, as well as some further information providing a more detailed list of the membership.

The purpose of the conference will be to provide a forum for information and discussion about critical issues that cut across the entire breadth of the aging field. It is expected that there will be in excess of 250 of the aging field's leaders, including the top business chief executive officers from the corporations involved in housing and health care, as well as the top leaders in the public and non-profit sectors. Congressman Claude Pepper has agreed to deliver the breakfast address, and NASLI has invited Senator Bob Dole to address the dinner gathering.

B

FINLEY KUMBLE WAGNER HEINE
UNDERBERG MANLEY MYERSON & CASEY

The Association would be deeply honored if you would consider delivering the keynote address at the luncheon convocation. We believe the occasion would provide an excellent opportunity to address issues related to aging and health of concern to you as well as your impressions of the pending tax legislation before an enthusiastic and supportive audience that will consist of a highly select group of leaders. The Association would, of course, be pleased to accommodate your schedule and the time constraints you may have. We are prepared to offer an appropriate honorarium for all of the time and preparation that would be required for your appearance.

We earnestly hope you will consider accepting this invitation. We would be pleased to provide whatever further information you may require.

Thank you for your consideration of this request.

With my very best wishes, I am

Yours very truly,

Frederick H. Graefe

Enclosures
FHG/mm

C

EMemo

September 18, 1986

TO: RGK, STC
FR: KMP
RE: BIZNET speaker costs

The cost for speakers at the BIZNET is as follows, per agreed upon arrangements internally and with the speakers:

Breakfast:	
Claude Pepper	$500 honorarium $295 registration comp.* breakfast
Lunch:	
David Durenberger	$2000 honorarium $ 295 registration comp* lunch
Dinner:	
Lydia Bronte	$100 hotel (1 night) $150 air fare (approx.) $295 registration comp.* all meals
Public Policy Track:	
Mike Hendrickson	$450 air fare (approx) $300 hotel (3 nights) $295 registration comp. all meals
Fernando Torres-Gil	$295 registration(comp.)* meals unknown at this time
Michael Sumachrast	$500 honorarium $850 membership in NASLI (comp.) $295 registration (comp.)* breakfast and lunch
Paul Kerschner	$295 registration (comp.)* breakfast and lunch
Harry Sewell	$295 registration (comp.) no meals
Senior Consumer Track:	
Ken Dychtwald	$1000 honorarium $ 450 air fare (approx.) $ 125 E&R membership in NASLI (Comp.) $ 100 hotel (one night) $ 295 registration (comp.)* all meals
Eliot Glazer	$ 295 registration (comp.)* all meals

*non-member

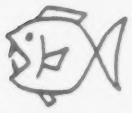
D

The associated expenses with the BIZNET speakers break down in the following manner:

honorariums, air fares, hotel rms.,	$5550.00
cost of meals for BIZNET but not paid for by speakers	$ 414.78
income lost due to comping registration and/or membership	$3925.00

E

PIRANHA



PRESS

Gary L. Diamond
Publisher

September 24, 1986

Mr. Fred Graefe
Finley, Kumble & Wagner, et al
1140 Connecticut Avenue NW
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Graefe:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Association of Senior Living Industries on September 25, 1986.

It is our understanding that you have already been informed of the terms of our arrangement with the Senator.

As you were informed, we are the publisher and promoter of Senator Durenberger's books. In consideration thereof, the Senator has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion and sale of his books.

Senator Durenberger will be appearing before your organization at the time and place specified in the attached schedule in consideration of the purchase by your organization of the number of books specified and payment by you to us of the sum set forth in such schedule.

Your organization is responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his Washington, DC office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

4504 EXCELSIOR BLVD. - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

F

Payment of the sums due us must be made to us within ten days from the date of this letter.

Because Senator Durenberger's appearance before your organization will be in promotion of his books, we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his books. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

G

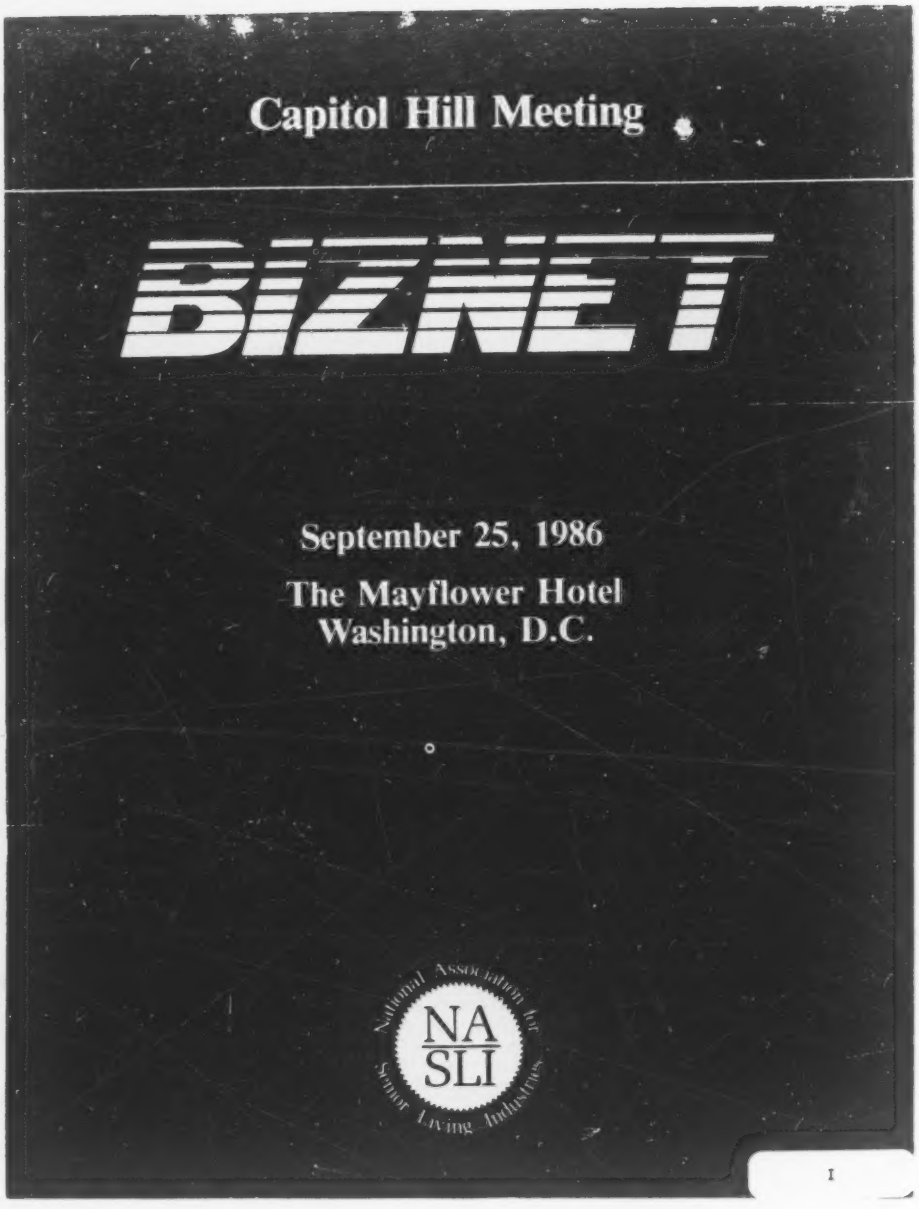
BOOK SALE AND APPEARANCE SCHEDULE

Date	Place	Amount
September 25, 1986	Washington, DC	$2,000

Book	Number of Copies	Price per Book	Place of Delivery	Date of Delivery
Prescription for Change	143	$7.00	Robert Kramer Executive Vice President NASLI 125 Cathedral Annapolis, MD 21401	9/25/86

*All books will be delivered by UPS on a COD basis.

H


Capitol Hill Meeting
BIZNET
September 25, 1986
The Mayflower Hotel
Washington, D.C.
National Association for Senior Living Industries
NA
SLI

BIZNET

To break new ground on Capitol Hill, NASLI will hold a Business Networking session (BIZNET) in Washington, D.C. on September 25, 1986, at the Mayflower Hotel. BiZNET is a semi-annual event designed to facilitate interaction between NASLI members who wish to explore mutual business and professional opportunities. The day-long event will be divided into two tracks, "Public Policy" and "Understanding The Senior Consumer".

Agenda

8:30 a.m. Breakfast

Guest Speaker
The Honorable Claude Pepper (D-FL), one of the nation's most visible spokesmen for older Americans, will address the role of the private sector and private/public sector partnerships in meeting the opportunities and needs presented by the growing number of older Americans.

Track 1
Public Policy

9:30 a.m. Come hear those involved in the process as well as those in the business explore the forces that shape your strategic plans.

Moderator: Michael Hendrickson, Ph.D., President, Retirement Systems Corp. of America, Pasadena, CA.

Presentations: Public Policy

I. **Legislative and Regulatory Outlook:**
- Important details of the tax reform bill and trends in tax reform—Joseph P. Dowley, III, Chief Counsel, House Committee on Ways and Means, U.S. Congress (invited).
- The urgency of developing public policy on housing and long-term care; latest public policy proposals and trends—Fernando Torres-Gil, Staff Director, House Select Committee on Aging, U.S. Congress.

II. **Economic Outlook:**
What bears close watching in the months and years ahead—Michael Sumachrast, Ph.D., Senior Economic Advisor, National Association of Home Builders, Washington, D.C.

III. **Industry Outlook:**
- Financing Long-Term Care—Dr. Paul Kerschner, President, National Foundation for Long-Term Care, Washington, D.C.
- Senior Housing Climate Today & Tomorrow—Harry Sewell, Vice President, Real Estate Financial Services, Baltimore, MD
- The Private Sector Responds to the Public Sector Trends—Paul Wilging, Ph.D., Executive Vice President, American Health Care Assoc., Washington, D.C.

Presentations will be followed by lively discussions of these far-reaching concerns.

J

Track 2
Understanding The Senior Consumer

9:30 a.m. We all know seniors are different—but how are they different? Come hear gerontological, consumer, advertising/research, and marketing experts provide key insights into the different purchasing patterns of seniors and how these insights can be applied in selling to seniors.

Opening Remarks: Joyce Cochenour, Vice President of NASLI Consumer Products & Services Council; National Chapter and Public Relations Director, *Mature Outlook, Inc.*

I. • Gerald Hotchkiss, Publisher, *50 Plus* Magazine. Older Americans will spend their money on brand new places, ideas, and things yet to be created. In tune with the market through years of experience, Hotchkiss will share his perspectives on senior consumers and the attitudes and rules which they are bringing to their purchases as they embark on brand new lifestyles.

II. • Ken Dychtwald, Ph.D., President, Age Wave. This noted gerontologist will take a glimpse into the future and explore the profound impact which the aging of America into healthier, more vigorous older adults will have on the worlds of work, leisure, politics, the family, healthcare, manufacturing, and marketing.

12:45 p.m. Lunch

Guest Speaker
The Honorable Richard Gephardt (D-MO), a prominent member of the Democratic Party and a leading legislator in the tax reform movement on Capitol Hill, will share the "inside story" about the new tax reform bill and the implications for those involved in senior markets.

Track 1

2:30 p.m. **How to be effective on Capitol Hill.**

- Learn from an expert how to effectively communicate your interests to the legislators who shape and define public policy—Frederick Graefe, NASLI Legislative Counsel; Partner, Finley, Kumble, Wagner et al, Washington, D.C.
- Visit to Capitol Hill—the remainder of the afternoon offers members the time to visit with their respective Congressmen and Senators. Contact information will be sent to all Public Policy Track BIZNET registrants with their confirmation letter.

Track 2

III. • Eliot Glazer, Director of Account Services, Cadwell Davis Partners. Glazer has recently spearheaded several national quantitative studies and a host of in-depth qualitative interviews with senior consumers. The conclusions reveal a truly fertile market with many real, unaddressed needs. Learn how this market is extremely sensitive and needs to be approached in a unique way.

IV. • Jim Schneider, The Jim Schneider Group. This veteran sales expert specializes in target marketing and service sensitivity to seniors. Schneider will complete the day's learning by showing you how to train your salestaff to successfully sell to seniors by first understanding them.

7:30 p.m. Dinner — Guest Speaker to be announced

Sponsorship

Track 1 Seminar is sponsored by NASLI Legal Services Council. Track 2 Seminar is sponsored by NASLI Consumer Products and Services Council.

Hotel and Travel Arrangements

To take advantage of special reduced rates at the Mayflower Hotel and special low air fares arranged for NASLI members, please contact Mary Ann Richter at Coast-to-Coast Travel, (305) 371-7273 no later than September 10 to secure your reservations.

Cut off and mail to NASLI. One registration form per person

Registration Form — Capitol Hill BIZNET, Sept. 25, 1986
(Please type or print)

Name:_____ Nickname for Badge:_____

Title:_____ Company:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Fee $295/per person*_____ Check enclosed _____

Credit Card: MasterCard ____ Choice ____ VISA ____

Number_____ Exp. Date_____

I am interested in attending the Public Policy Track____, or the Senior Consumer Track____

*Only NASLI Founding, Sponsor and Sustaining members may attend BIZNET sessions.

This form is for Capitol Hill BIZNET only. You must use separate Legal Issues Seminar Form to register for Legal Issues Seminar.

To secure hotel and travel arrangements contact Mary Ann Richter, Coast-to-Coast Travel, at (305) 371-7273.

Please fill out Business Opportunities form on reverse side.

The National Association for Senior Living Industries
125 Cathedral Street, Annapolis, Maryland 21401 (301) 263-0991

Seminar Information

Date: Thursday, September 25, 1986

Time:
7:45 a.m. — Registration opens
8:30 a.m. — Breakfast
9:30 a.m. — Track 1 & 2 begin
12:45 p.m. — Lunch
2:30 p.m. — Track 1 & 2 continue
6:30 p.m. — Reception
7:30 p.m. — Dinner

Place: The Mayflower Hotel
Washington, D.C.

Fee: $295 per person — NASLI members only

Registration: BIZNET is for NASLI members only. Fee includes seminar, all handout materials, three meals and reception.

Fill out and mail in with payment to:
The National Association for Senior Living Industries
125 Cathedral Street
Annapolis, MD 21401

Please duplicate form for additional attendees.

Refunds: Full refunds less a $30 processing charge will be granted upon written request received by Sept. 15. No refunds after that date.

Capitol Hill BIZNET, September 25, 1986

Business Opportunities Interest Statement

(Please print clearly or type)

I am particularly interested in:

Locating:
- ☐ Joint Venture Partners
- ☐ Developers interested in resident group purchase programs, e.g. insurance, travel

Securing financing for:
- ☐ Land acquisition
- ☐ Construction
- ☐ Other_____

Finding an experienced:
- ☐ Architect ☐ Healthcare Operator ☐ Community Manager
- ☐ Marketing and Sales Organization ☐ Developer ☐ Attorney ☐ Other_____

☐ Identifying sites for development
- ☐ Buying a site
- ☐ Buying a facility
- ☐ Selling a site
- ☐ Selling a facility

M

Comments: _____

Name _____

Title _____ Phone_____

Organization _____

Address _____

City/State/Zip _____

Important: To be included in the Capitol Hill BIZNET booklet (given to every BIZNET attendee) you must complete the above form and mail with your registration form.

Capitol Hill
BIZNET
125 Cathedral Street
Annapolis, Maryland 21401

The National Association for Senior Living Industries

N

NATIONAL ASSOCIATION
FOR SENIOR LIVING INDUSTRIES
125 CATHEDRAL STREET
ANNAPOLIS, MD 21401

1014

154
540

November 20 19 86

PAY TO THE ORDER OF PIRANHA PRESS

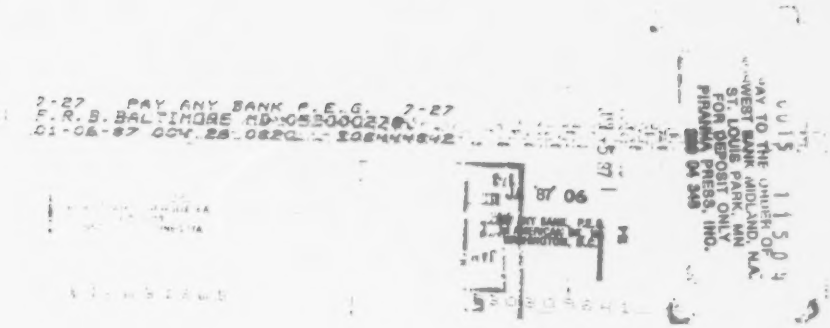
01-06-87 034 25 0820 $ 1001.00

One thousand, one ----------00/100---------- DOLLARS

1ST AMERICAN
FIRST AMERICAN BANK, NA, WASHINGTON DC

FOR Durenberger's book Prescription
for Change

⑈001014⑈ ⑆054000043⑆ 3 401 239⑈ ⑈0000100100⑈


2-27 PAY ANY BANK F.E.G. 2-27
F.R.B. BALTIMORE MD 053000220
01-05-87 0CV 25 0820
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NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
87 06

NATIONAL ASSOCIATION
FOR SENIOR LIVING INDUSTRIES
125 CATHEDRAL STREET
ANNAPOLIS, MD 21401

1017

Nov. 20 19 86 54-1/540

PAY TO THE ORDER OF David Durenberger 01-27-87 CD+ 26 0830 +0831 1233 $ 1,000.00

one thousand ----------00/100---------- DOLLARS

1st AMERICAN

FOR Honorarium/AIENT SEMINAR

Robert G. Lunn

⑈00 1 0 1 2⑈ ⑆054000043⑆ 3 40 1 235⑈ ⑈0000 1 00000⑈

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NORWEST BANK MIDLAND, N.A.
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FOR DEPOSIT ONLY
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JA '87 27
WASHINGTON, D.C.

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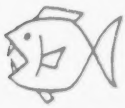


PRESS

Gary L. Diamond
Publisher

July 19, 1985

Mr. Michael J. Sheehan
Thompson, Hine and Flory
1100 National City Bank Bldg.
Cleveland, OH 44114

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Sheehan:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National City Bank of Cleveland, Ohio on September 13, 1985.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

SPECIAL
COUNSEL
HEARING
EX. 168

A

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Anne Kelly
Ms. Kitty Gamble

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
September 13, 1985	8:00 a.m.	Cleveland, Ohio	$5,000

C

EMPLOYEE NO.

REQUEST FOR REIMBURSEMENT FOR BUSINESS EXPENSES

	A 19__ MO./DAY	B PLACE (Address)	C NO. OF MILES	D PARKING & TOLLS	E MEALS & TIPS	F TAXIS BK CAR AUTO RENT	G TOTAL
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.			TOTAL MILES AT ____ ¢ PER MILE EQUALS	77105	77118	77105	
17.	LODGING Attach receipted bills for lodging, regardless of amount						
18.	TRANSPORTATION Attach receipts						
19.	CLUB DUES AND ASSESSMENTS (Explain in detail reverse side - page 2)						
20.	ASSOCIATION DUES (State name and period covered)						
21.	ENTERTAINMENT (Explain in detail on reverse side - page 2)						
22.	MISCELLANEOUS (Explain in detail on reverse side - page 2)						2,500.00
23.	ADD NEW ADVANCE (State purpose)						
24.							
25.	BUSINESS PURPOSE OF TRIP, if expenses for trip are included in this total						2,500.00
26.							
27.	If Line 28 is greater than line 25, Please attach your personal check payable to National City Bank in the amount of						2,500.00
28.	Make Check Payable To: PIRANHA PRESS		Send To (Section, Branch, etc.): WILL PICK UP				
29.	Employee Signature: David A. Clark x7939		Approved By (Dept. Head): Thomas F. Dunnerty				

SECTION NO. 2.0.0.0

Attach receipt for any separate expenditure of $25. or more

NOTES ON COLUMNS

B. Use address if not in town.

C. Use 10 mi. for one way trip between main office & op. center

F. Include in this column Bank car expenses (gas, oil, wash, etc.)

Sub-Total	
77105	
77118	
77105	
77143	
77209	
77122	
77215	
19416	
Total Expenses & New Advances	
Deduct Old Advance	
Balance	
Accuracy Verified	C
Comptroller Review	

71046-7 (REV 4-80)

Page 2

CLUB DUES and ASSESSMENTS

NAME OF CLUB	PERIOD COVERED BY DUES	REASON FOR ASSESSMENTS	AMOUNT
		Total Club Dues and Assessments — Carry Forward to Page 1 Line 19	

ENTERTAINMENT

198__ MO/DAY	PLACE (Address)	NATURE OF ENTERTAINMENT	GUESTS				AMOUNT
			NAME	TITLE	COMPANY NAME	BUSINESS PURPOSE	
						Total Entertainment — Carry Forward to Page 1 Line 21	

DATE	NATURE OF MISCELLANEOUS ITEMS AND/OR EXPLANATION	
8/85	Senator David Durenberger - fee for Health Care Seminar sponsored by NCB	$2,500.00
	Total Miscellaneous — Carry Forward to Page 1 Line 22	$2,500.00

71046-7 (REV. 4-80)

(9627A)08/19/85

INTER-OFFICE CORRESPONDENCE

TO: Bill Thomas FROM: Lu Huston DATE: 8/19/85

RE: Senator Durenberger

Enclosed is a draft of a letter to Gary Diamond at Piranha Press, which outlines our understanding. Before you send it, Mike Sheehan at Thompson, Hine would like to review it. Because there is not all that much time, I suggest you call him and take the draft over.

Please note we have agreed to pay $2,500, with the sending of this letter and the remaining $2,500 of the fee when the senator is here to speak. The $2,500 paid now is to be completely refunded if he cancels for any reason we did not cause. You should request a check to enclose with the letter and a second one to be made on the date of the speaking engagement.

Note also all travel and hotel accommodations are to be made by the Bank in advance and confirmed through Senator Durenberger's office. Tickets should be sent to arrive at his office not later than September 9, 1985. You probably will want to take care of that this week.

cc: Tom Dougherty (with enclosure)

NATIONAL CITY BANK
National City Center
Post Office Box 5756
Cleveland, OH 44101-0756
Phone 216/575-2000

August 19, 1985

Gary Diamond, President
Piranha Press
4504 Excelsior Boulevard
Minneapolis, Minnesota 55416

Re: Senator David Durenberger, speaking engagement as keynote speaker for Horizons in Health Care, on September 13, 1985, at 8:00 a.m., at National City Bank, 1900 East Ninth Street Cleveland, Ohio

Dear Mr. Diamond:

This letter constitutes agreement between National City Bank and Piranha Press regarding the speaking engagement referred to above.

It is mutually understood that payment and performance by National City Bank under this letter agreement is in consideration of Senator Durenberger's appearance and keynote address to Horizons in Health Care, sponsored by National City Bank, on September 13, 1985, the Senator to appear between 8:30 a.m. and 10:30 a.m. on that day.

Enclosed is a check for $2,500, which is advance payment of one-half of the fee for the above engagement, the balance of $2,500 to be paid on September 13, 1985, unless the engagement has earlier been canceled.

It is understood and agreed that, because of Senator Durenberger's commitments as a United States Senator, he cannot guarantee his appearance and may not be able to give any advance notice of changes in his plans so as to allow for the scheduling of another speaker. In the event, however, Senator Durenberger does not appear for any reason other than breach by National City Bank of this letter agreement, Piranha Press shall promptly, upon request, refund 100 per cent of the sum advanced with this letter by National City Bank to Piranha Press.

G

National City Bank will make, and pay for in advance, all travel arrangements and accommodations for Senator Durenberger. All travel arrangements will be confirmed through the Senator's office in advance of September 13 and tickets will be forwarded to be received by his office not later than September 9, 1985.

If the foregoing accords with your understanding of our agreement, please sign the enclosed copy of this letter and return it to the undersigned.

Very truly yours,

Thomas F Dougherty

Thomas F. Dougherty
Senior Vice President

Acknowledged and approved:

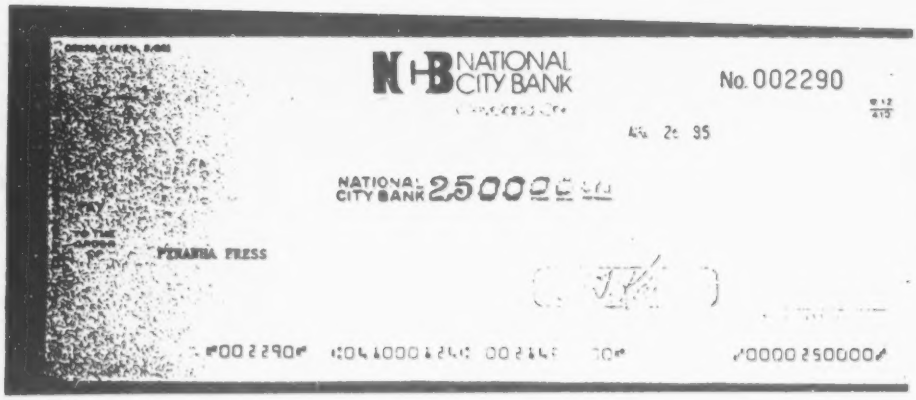
_____

Gary Diamond
Piranha Press

Date _____

cc: Michael Mahoney, Esq.
M. Griffin, Program Coordinator
D. Clark

H


NATIONAL CITY BANK

No. 002290

Aug 26 95

NATIONAL CITY BANK 2500.00

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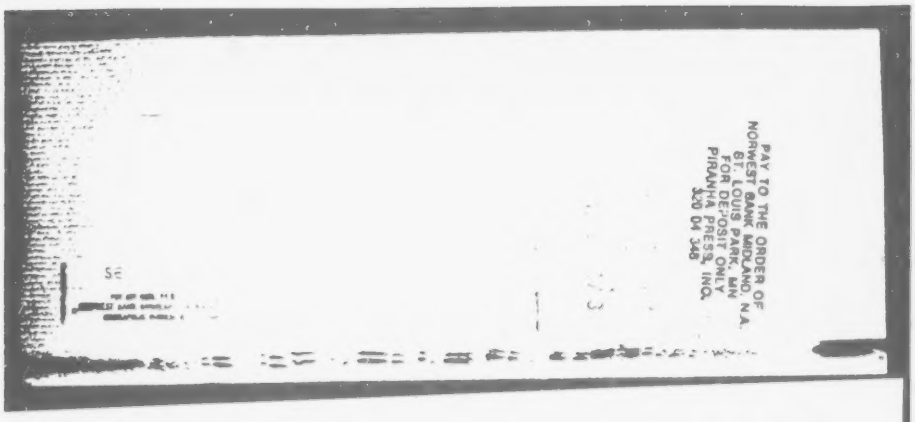
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1100 NATIONAL CITY BANK BUILDING
CLEVELAND, OHIO 44114
(216) 566-5500 · TELEX 980317

IN COLUMBUS, OHIO
100 EAST BROAD STREET
COLUMBUS, OHIO 43215
(614) 461-8060

IN PALM BEACH, FLORIDA
125 WORTH AVENUE
PALM BEACH, FLORIDA 33480
(305) 833-8900

IN WASHINGTON, D.C.
1920 N STREET, N.W.
WASHINGTON, D.C. 20036
(202) 331-8800 · TELEX 904173

WRITER'S DIRECT DIAL NUMBER
(216) 566-5626

August 28, 1985

Ms. Kelly Johnson
Office of Senator Durenberger
United States Senate
SR-375
Washington, D.C. 20510

Dear Ms. Johnson:

Enclosed please find airline tickets for Senator Durenberger's travel on September 12-13, 1985. You should note that the tickets provide for travel from Washington, D.C. (National) to Cleveland, Ohio and from Cleveland to Minneapolis, Minnesota. We have not made arrangements for the Senator's return to Washington, D.C. because you indicated that your office would undertake this responsibility.

Note further that enclosed are two tickets for travel to Cleveland: one for the evening of September 12 and one for the morning of September 13. We hope that the Senator is able to attend a dinner with us Thursday evening, however, we are well aware of the fact that his duties in Washington may not permit this. Please notify us as soon as you are able in this regard.

By the time you receive this letter, you should also have received a copy of the invitations from National City Bank. Also, I hope that by this time, I will also have received the Senator's written remarks and biography information.

Once again, I look forward to meeting with the Senator in two weeks. Thank you for your kind cooperation.

Very truly yours,

MJS/sf

Enclosures

Michael J. Sheehan

cc: Michael Mahoney, Esq.
Mr. James Roan
Ms. Michelle Griffin

K

THOMPSON, HINE AND FLORY
1100 NATIONAL CITY BANK BUILDING
CLEVELAND, OHIO 44114
(216) 566-5500 · TELEX 980317

IN COLUMBUS, OHIO
100 EAST BROAD STREET
COLUMBUS, OHIO 43215
(614) 461-6060

IN PALM BEACH, FLORIDA
125 WORTH AVENUE
PALM BEACH, FLORIDA 33480
(305) 833-3800

IN WASHINGTON, D.C.
1920 N STREET, N.W.
WASHINGTON, D.C. 20036
(202) 331-8800 · TELEX 904173

RECEIVED
RECEIVED

August 28, 1985

DIRECT DIAL NUMBER
(216) 566-5626

Michael Mahoney, Esq.
4150 Multifoods Tower
Minneapolis, Minn. 55402

Dear Mr. Mahoney:

Enclosed please find a copy of the Agreement signed by National City Bank and delivered to Piranha Press. I understand that this document reflects the agreement reached between National City's legal counsel and Mr. Diamond through phone conversations. We, of course, appreciate your assistance in this regard.

We are looking forward to the Health Care Forum and Senator Durenberger's appearance. If there are any other matters with which we may be of assistance in the meantime, please feel free to contact me at the direct dial number indicated above.

Once again, thanks.

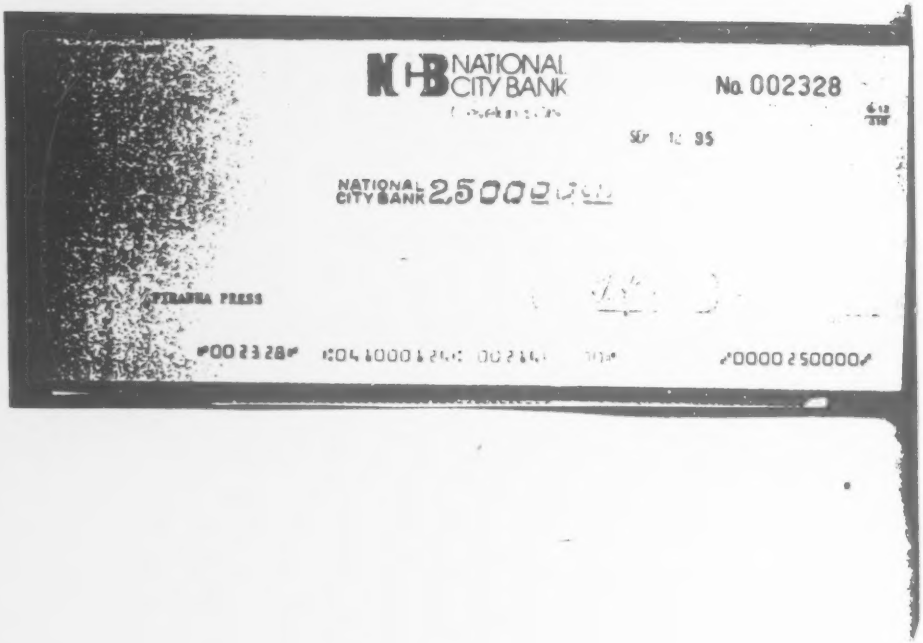
Very truly yours,

Michael J. Sheehan

MJS/sf

Enclosure

TO: SKA
for DD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PHARMA
320 04 348

Memorandum

To: Senator
From: Chip and Mary
Date: 9-12-85

Re: "New Horizons in Health Care" seminar, National City Bank

Approximately 250 people will be at the seminar, consisting primarily of CEO's, Chief Financial Officers, and Executive VP's of Manufacturing corporations, hospitals, third party payers, PPO's, and HMO's. Also present will be a number of human resources/employee benefits executives. Most everyone will be from the Northern Ohio area.

The audience comes with a good grasp of the issues you will be speaking about. Since many will be financial people you can get as technical as you want.

You will have one hour, 8:45 to 9:45, with which you can do what you want. Undoubtedly the participants will be a lively, interested group, so would appreciate 15 to 30 minutes of Q & A. Mike Sheehan mentioned he may start you early in case you need the time afterward to catch your plane.

Program Agenda

Your address will be preceeded by Edward B. Brandon, President and CEO of National City Bank. Briefly the rest of the program is as follows:

In the morning will be John Burry, Pres. and CEO of BC/BS of Northern Ohio. Also two attorneys from Thompson, Hine, and Flory (represent National City Bank) will speak.

At noon will be a panel, consisting of Dr. Robert Fetter, (developer of DRG's), who is an educator at Yale School of Management; executives of human resources/employee benefits areas of large manufacturing and service industries, one of whom is the President of Toledo Business Coalition on Health Care; the Chief Financial Officer of University Hospital of Cleveland (Case Western Reserve's hospital); and the Senior VP of Operations, St. Vincents Hospital, Cleveland.

In the afternoon will be the Senior Executive VP of BC/BS of Northern Ohio; representatives of National City Bank; partner (health expert) of Ernst and Whinney; President of Center for Health Affairs, Greater Cleveland Hospital Association; and ending with representatives of National City Bank.

FOLIO

BOND COURT HOTEL

777 ST. CLAIR AVENUE
CLEVELAND, OHIO 44114
(216) - 771-7600

ROOM	NAME	RATE	DEPART	TIME
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TYPE	FIRM OR GROUP	CODE	ARRIVE	TIME
N3	07 NATIONAL CITY BK	COR1	9 12 85	

ROOM CLERK 275

1900 E 9TH/METRO DIV
CLEVELAND,OH
4114
ADDRESS

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MEMO	DATE	REFERENCE	CHARGES	CREDITS	BALANCE DUE
	9/12	PHONE	1.00		
	9/12	RM 1302	72.00		
	9/12	TX 1302	9.00		
	9/13	CL #1864			82.00

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company, or association fails to pay for any part or the full amount of these charges.

GUEST SIGNATURE

BOND COURT HOTEL

P

10: Mahoney / Tamara
FROM: DD/JODI

4/7-9/86

NATIONAL GROCERS ASSOCIATION

Headquarters Office
1825 Samuel Morse Drive
Reston, Virginia 22090
(703) 437-5300

Public Affairs Office
1910 K Street, N.W. Suite 700
Washington, D.C. 20006
(202) 955-8400

Contact: Dick Bolger
202-955-8400
$2K is O.K.

agreed to 3/5/86
telecopied 3/5/86

January 31, 1986

The Honorable David Durenberger
154 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

$2,000 (P.P.)

Dear Senator Durenberger:

On behalf of the National Grocers Association, I would like to invite you to speak at our annual Public Affairs Conference, scheduled for April 7-9, 1986, in Washington, D. C. We would be honored if you would address the subject of "Balancing the Budget and Tax Reform" on:

Monday, April 7, 1986
3:00 p.m. - 3:45 p.m.
Hyatt Regency, Capitol Hill
Washington, D. C.

N.G.A. members represent the small business sector of the food distribution industry and include 1,900 retail grocery firms, 61 wholesale distribution centers, and 63 state and local food associations, including the Minnesota Grocers Association located in St. Paul, Minnesota. We anticipate an audience of approximately 400 people in attendance.

The purpose of the 1986 conference is to provide a format through which government leaders and our members can mutually benefit from an exchange of legislative and regulatory information affecting the retail grocery and food distribution industry. The conference theme of "You Make the Difference" highlights the effect grocers working with members of Congress can have on the decision-making process in Washington. Your participation in the meeting will significantly contribute to its success.

I sincerely hope that you will be able to accept our invitation and look forward to your participation in the conference. Dick Bolger of my staff will call your office in the near future to provide any additional information that you may need.

Sincerely,

Re: balancing the budget; tax reform DL up. for
will provide list of Minnesotans attend
3 seats requested

Thomas F. Wenning

Thomas F. Wenning
Executive Vice President
and General Counsel

TFW/lg

SPECIAL COUNSEL HEARING EX. 169

PIRANHA

PRESS

Gary L. Diamond
Publisher

March 12, 1986

Mr. Dick Bolger
National Grocers Association
Public Affairs Office
1910 K Street NW
Suite 700
Washington, DC 20006

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Bolger:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Grocers Association on April 7, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

B

Mr. Dick Bolger
National Grocers Association
March 12, 1986
Page 2

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

C

APPEARANCE SCHEDULE

Date	Place	Amount
April 7, 1986	Washington, DC	$2,000

D

TO: Accounting

FROM: DB DB

RE: Public Affairs Conference honorariums.

We will need the following honorariums for speakers for the 1986 Public Affairs Conference:

~~1. Sen. Dave Durenberger, $2,000 payable to Piranha Press. Earlier requested~~

1. Sen. Lowell Weicker, $1,000, to be hand delivered at the Public Affairs Conference. Address: U.S. Senate Washington, DC 20510.

2. John Mashek, $750, to be hand delivered at the Public Affairs Conference. Address: U.S. News and World Report, 2400 N Street, N.W., Washington, D.C. 20037

3. Rep. Tom DeLay, $500, to be hand delivered at the Public Affairs Conference, Address; U.S. House of Representatives Washington, D.C. 20515

~~4. Sen. Wendell Ford, _____, to be hand delivered at the Public Affairs Conference. Address: U.S. Senate, Washington, D.C. 20510~~

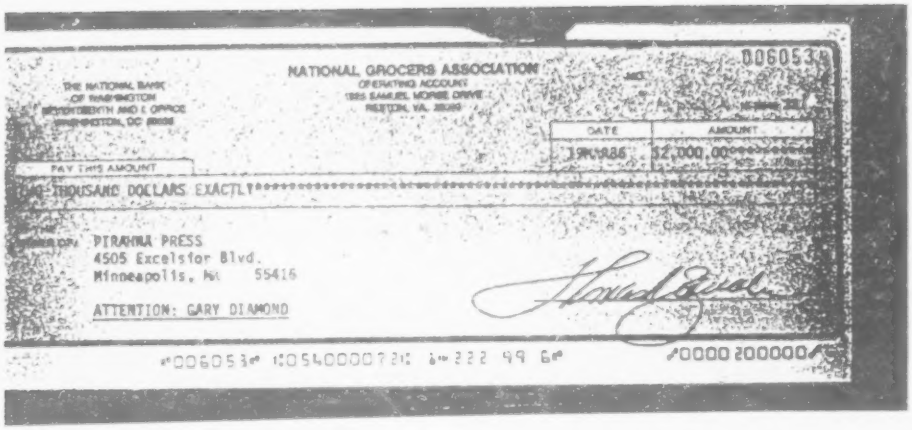
March 28, 1986

OK J.F.L.J.

Barbara/Charlie:
I am going to confirm the $ amount for DeLay on Monday, March 31. →
Dick

NG.7 check

E



006053

THE NATIONAL BANK OF WASHINGTON
SEVENTEENTH AND E OFFICE
WASHINGTON, DC 20006

NATIONAL GROCERS ASSOCIATION
OPERATING ACCOUNT
1825 SAMUEL MORSE DRIVE
RESTON, VA. 22090

DATE	AMOUNT
1PR1986	12,000.00

PAY THIS AMOUNT

TWELVE THOUSAND DOLLARS EXACTLY**********

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4505 Excelsior Blvd.
Minneapolis, MN 55416

ATTENTION: GARY DIAMOND

Howard Byrd

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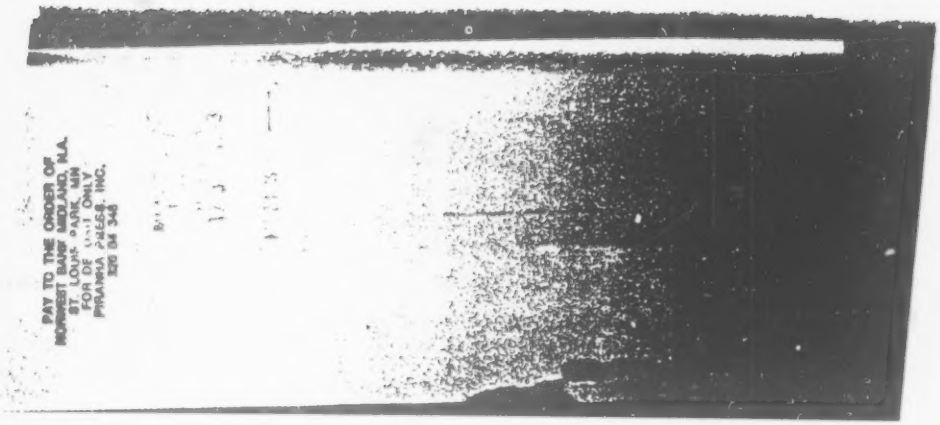
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K.REQ.	03/19/86	#13957 MR 3/26	SPEAKER HONORARIUM TO SEN. THE N.G.A.	5200-0301	Batch # 02401 DURENBURGER FOR PUBLIC AFFAIRS CONFERENCE.	$2,000.00

ACH AT PERFORATION BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

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THE NATIONAL BANK OF [illegible] CENTRAL ENTERPRISE CORP. WASHINGTON, DC [illegible]

[illegible] WASHINGTON, D.C. [illegible]

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Minneapolis, MN 55416

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H

NATIONAL GROCERS ASSOCIATION

Headquarters Office
1825 Samuel Morse Drive
Reston, Virginia 22090
(703) 437-5300

Public Affairs Office
1910 K Street, N.W., Suite 700
Washington, D.C. 20006
(202) 955-8400

March 24, 1986

The Honorable Dave Durenberger
U.S. Senate
375 Russell Building
Washington, DC 20510

Dear Senator Durenberger:

Between April 7-9, 1986, the membership of the National Grocers Association will be in Washington to discuss with you the issues that concern their businesses. Our membership consists of over 2,000 retail grocers and the wholesalers who serve them. President Reagan accurately described N.G.A. members when he said, "I cannot think of a better example of small businesses' contribution to our country's economic well being than that of the independent retail grocer."

You have already received an invitation to join us for breakfast on Capitol Hill on April 9. As a reminder, we have enclosed another invitation and hope you will be able to join us. In light of your full schedule and abundance of evening engagements, we have scheduled a special breakfast so that you can conveniently spend a little time with grocers from back home.

Next week, you and your key staff will receive a set of issue papers from N.G.A. N.G.A. members are interested in discussing:

* Retaining investment incentives for small business in tax legislation;
* Addressing the insurance crisis hitting the business community;
* Assuring fair and consistent standards of antitrust law enforcement;
* Continuing the process of truck deregulation;
* Allowing private employers to continue the reasonable use of polygraphs.

This year's theme of "You Make the Difference" emphasizes the importance of the grocers' personal contact with you here in Washington. I hope you will accept our invitation to participate in the kind of exchange of ideas which is essential to our legislative process.

If you or your staff have any questions or comments, please do not hesitate to call the N.G.A. Public Affairs Office at (202) 955-8400. In addition, you can R.S.V.P. for breakfast by calling the same number.

Sincerely,

Thomas K. Zaucha
President & CEO

Enclosures

NATIONAL
GROCERS
ASSOCIATION

Headquarters Office
1825 Samuel Morse Drive
Reston, Virginia 22090
(703) 437-5300

Public Affairs Office
1910 K Street, N.W. Suite 700
Washington, D.C. 20006
(202) 955-8400

March 26, 1986

Mr. Daniel Coborn
Arrowhead Apts.
2430 Southwest 81st Ave., #107
Davie, FL 33324

Dear Dan:

Thank you for agreeing to introduce Sen. Dave Durenberger (R-MN) at the N.G.A. Public Affairs Conference on April 7 at 3:00 p.m.. A short introduction is being prepared for you to deliver as part of the day's program and will be given to you at the conference.

In the meantime, if you have any questions please do not hesitate to call me at (202) 955-8400. I look forward to seeing you here in Washington.

Sincerely,

Richard O. Bolger
Director of Government Relations

ROB/lg

3PM KONDOR RETURNS

I CAN THINK OF NO TWO ISSUES MORE IMPORTANT TO US AS BUSINESSMEN AND WOMEN, AND AS CITIZENS, THAN THE BUDGET DEFICIT AND TAX REFORM. WE HAVE WITH US TODAY ONE MEMBER OF THE U.S. SENATE WHO SEES THE TWO AS INTERRELATED. HERE TO INTRODUCE OUR NEXT SPEAKER IS DON COBORN OF COBORN'S IN ST. CLOUD, MINNESOTA AND A MEMBER OF THE N.G.A. BOARD OF DIRECTORS.

COBORN SPEAKS

THANK YOU, JIM. WE ARE INDEED PRIVILEGED TO HAVE WITH US TODAY, SENATOR DAVE DURENBERGER, A NATIVE OF ST. CLOUD, MINNESOTA. AS THE ORIGINAL SPONSOR OF LEGISLATION WHICH WILL PROHIBITED BANKERS FROM CHARGING RETAILERS FOR REDEEMING FOOD STAMPS, HIS SUPPORT FOR OUR INDUSTRY IS UNQUESTIONED.

Monday, April 13, 1981 Continuity

K

SENATOR DURENBERGER IS A MEMBER OF THE FINANCE COMMITTEE WHICH IS CURRENTLY DRAFTING AND VOTING ON A COMPREHENSIVE TAX BILL. THAT BILL WILL HAVE A DRAMATIC EFFECTS ON FOOD RETAILING AND WHOLESALING. CHANGES IN TAX RATES, INVESTMENT INCENTIVES, CAPITAL COST RECOVERY AND EXCISE TAXES REPRESENT A MAJOR RESHUFFLING OF THE "DECK OF CARDS" WE CURRENTLY KNOW AS THE TAX CODE. HOW THE DECK WILL BE STACKED IS AN IMPORTANT QUESTION, ESPECIALLY WITH BUDGET PRESSURES TO REDUCE THE DEFICITS. SENATOR DURENBERGER HAS SOME KEY INSIGHTS INTO THE LEGISLATIVE PROCESS WHICH WILL ADDRESS TAX REVISION ISSUES IN THE SENATE. HE ALSO SERVES ON THE ENVIRONMENT AND GOVERNMENT AFFAIRS COMMITTEES AND IS CHAIRMAN OF THE SELECT COMMITTEE ON INTELLIGENCE.

FIRST ELECTED IN 1978, DAVE DURENBERGER IS IN THE MIDST OF HIS SECOND TERM IN THE SENATE. HE IS A GRADUATE OF ST. JOHN'S UNIVERSITY AND THE UNIVERSITY OF MINNESOTA LAW SCHOOL. BEST OF ALL, HE IS A NATIONAL FIGURE WHO HAS NOT FORGOTTEN HIS HOMETOWN ROOTS. LADIES AND GENTLEMEN, I AM PROUD TO INTRODUCE TO YOU SENATOR DAVE DURENBERGER.

"YOU MAKE THE DIFFERENCE"

1986 PUBLIC AFFAIRS CONFERENCE

APRIL 7-9

HYATT REGENCY CAPITOL HILL

WASHINGTON, D.C.

NATIONAL GROCERS ASSOCIATION

WELCOME TO WASHINGTON

NATIONAL GROCERS ASSOCIATION

1986

PUBLIC AFFAIRS CONFERENCE

Welcome to Washington, and to the 1986 N.G.A. Public Affairs Conference. This year's conference, "You Make the Difference" marks the tenth anniversary that retail grocers and their wholesalers have been coming to Washington to meet with their representatives and senators on Capitol Hill.

This year the Public Affairs Conference is particularly timely because it comes at a time when Congress is making legislative decisions on issues that will affect members of the food distribution industry now and for years to come. This 1986 Public Affairs Conference provides the opportunity for us to meet with our elected representatives individually and in a group to discuss tax legislation, the insurance crisis, antitrust enforcement, truck deregulation, and polygraph tests. The program features senators, congressmen, and congressional staff, and is packed with experts who know how Washington works, and how you can work to influence the decision makers.

The conference coincides with Washington's Annual Cherry Blossom Festival, a lovely time of year to be in our nation's capital. We hope you will take this opportunity to see some of Washington, and to help "make the difference" in the public policy affecting our industry.

Again, welcome, and our very best wishes for an enjoyable and informative visit!

CONFERENCE COMMITTEE

James Kondor
Conference Chairman
Kondor's Thriftway of Winter Haven
Winter Haven, FL

Virgil Froehlich
Affiliated Foods Cooperative, Inc.
Norfolk, NE

Thomas Infusino
Nutley ShopRite, Inc.
Nutley, NJ

Hillar Moore
Associated Grocers, Inc.
Baton Rouge, LA

Everett Suddreth
North Carolina Food Dealers Association
Charlotte, NC

N

The following associations are co-sponsoring

"YOU MAKE THE DIFFERENCE"

Retail Grocers Association of Arizona	Paul Bennewitz, Executive Director
California Grocer Association	Donald Beaver, President
North California Grocers Association	Karen Schulke, President
Southern California Grocers Association	Steve Koff, President
Retail Merchants Association of Canada (Ontario) Inc	John Gillespie, President
Rocky Mountain Food Dealers Association	Lynn Callison, President
Connecticut Food Stores Association	Grace Nome, Executive Director
Retail Grocers Association of Florida, Inc	Bill Weaver, President
Georgia Grocers Association	E. Wayne Stanford, Executive Director
Hawaii Food Industry Association	Richard C. Botti, Executive Director
Idaho Retailers Association	J. Tim Brennan, President
Illinois Food Retailers Association	Philip P. Fazio, Executive Director
Iowa Retail Food Dealers Association	Patricia Smallenberger, Executive Director
Jayhawk Food Dealers Association	Robert S. Mace, Executive Director
Kansas Food Dealers Association	James G. Sheehan, Executive Director
Retail Grocers Association of Greater Kansas City	James G. Sheehan, Executive Director
Kentucky Grocers Association	Patrick Hicks, Executive Director
Louisiana Wholesale Grocers Association, Inc	Barbara J. Easley, Executive Director
Maine State Grocers Association	Arthur Charles, Executive Director
Mid-Atlantic Food Dealers Association	William Miller, President
Michigan Food Dealers Association	Paul K. Fershee, Jr. Executive Director
Minnesota Food Dealers Association	Joel Holland, President
Metro Food Dealers Association	Clarence B. Shaul, Executive Director
Missouri Retail Grocers Association	George Dillard, Executive Director
Montana Retail Grocers Association	Frank Capps, Executive Director
Nebraska & Omaha Food Retailers Association, Inc	George Prucha Executive Director
New Hampshire Retail Grocers Association	John M. Dumais, President
New Mexico Food Dealers Association, Inc	Thuett Gill, Executive Director
North Carolina Food Dealers Association	G. Everett Suddreth, Jr. Executive Vice President

North Dakota Food Retailers Association	Tom Woodmansee, President
Central Ohio Retail Grocers Association	Don E. Williams, Executive Director
Cleveland Food Dealers Association, Inc	Alvin J. Palack, Executive Director
East Central Ohio Food Dealers Association	Richard Hetherington, President
Ohio Grocers Association	Richard Hetherington, President
Youngstown Area Grocers Association	Charles Burkey, Executive Director
Oklahoma Retail Grocers Association	Elden Roscher, Executive Director
Association of Oregon Food Industries, Inc	Steve McCoid, President
Pennsylvania Food Merchants Asscciation	David McCorkle, Executive Director
Pennsylvania Grocers Association	John McNelis, Executive Secretary
Food Retailers Association of South Carolina	William Platt, Executive Director
South Dakota Retailers Association	Dean Randall, President
Tennessee Retail Grocers Association	Wesley A. Ball, Executive Director
Corpus Christi District Retail Grocers Association	Dorothy Krause, Executive Director
North Central Texas Food Industry Association, Inc	Daisy Fern Nelson, Executive Director
Retail Grocers Association of Houston, TX	Rick Johnson, Executive Director
San Antonio Retail Grocers Association	Jerry Walker, Executive Director
Texas Retail Grocers Association	Charles Knapp, Executive Director
Utah Retail Grocers Association	James Olsen, President
Vermont Retail Grocers Association, Inc	James E. Holmes, Executive Vice President
Virginia Food Dealers Association, Inc	John G. DeMoss, Executive Director
Washington State Food Dealers Association	Henry G. Sitko, Executive Director
West Virginia Association of Retail Grocers	Edward Neill, President & CEO
Wisconsin Grocers Association	John Ellingson, President

PROGRAM

MONDAY, APRIL 7

8:00 a.m.-6:00 p.m. **REGISTRATION OPEN**
Regency Foyer Lobby

8:30 a.m.-9:30 a.m. **WOMEN GROCERS OF AMERICA (W.G.A.) BOARD MEETING**
Sequoia Room

9:30 a.m.-11:00 a.m. **W.G.A. HOSPITALITY**
Valley Forge Room

11:00 a.m.-11:30 a.m. **W.G.A. DISTINGUISHED SPEAKER FORUM**
Bunker Hill Room

Topic: "AN INSIDER'S VIEW OF THE CAPITOL"

Speaker: Kathy Calhoun
Administrative Assistant
Congressman Andy Ireland

1:00 p.m.-5:00 p.m. **OPENING GENERAL SESSION**
Regency A

Chairman-of-the-Day: James Kondor
Kondor's Thriftway of Winter Haven
Winter Haven FL

• • •

Welcome: Jere Lawrence
N.G.A. Chairman of the Board
Lawrence Management Co.
Sweetwater, TX

• • •

Topic: "ANTITRUST ENFORCEMENT CONGRESSIONAL OVERSIGHT"

Introduction: Patrick Hicks
Kentucky Grocers Association
Louisville, Kentucky

Speaker:

The Honorable Wendell Ford (D-KY) U.S. Senate

• • •

Topic: "PUBLIC POLICY AND FOOD DISTRIBUTION EFFICIENCIES: A LOOK AT TRUCK DEREGULATION"

Introduction: Jimmy Falik
Great Valu Foods
Houston, TX

Speaker:

The Honorable Tom DeLay (R-TX) U.S. House of Representatives

• • •

2:45 p.m.-3:00 p.m. **REFRESHMENT BREAK**
Regency Foyer

• • •

Keynote Address: "BALANCING THE BUDGET AND TAX REFORM"

Introduction: Daniel Coborn
Coborn's Inc.
St. Cloud, MN

Speaker:

The Honorable Dave Durenberger (R-MN) U.S. Senate

• • •

Topic: "CONGRESSIONAL STAFF ISSUES FORUM"

P

Introduction: Thomas K. Zaucha
President and CEO
National Grocers Association

Panelists: Charles Ludlum
Deputy Minority Staff Director
and Chief Tax Counsel
Senate Committee on Small
Business

Richard Patrick
Legislative Assistant
Rep. Buddy Darden (D-GA)

Eddie Correia
Minority Chief Counsel
Senate Judiciary Subcommittee
on Administrative Practice

6:00 p.m. **RECEPTION**
Regency Foyer

7:00 p.m. **N.G.A. Salutes**
HENRY BISON, JR.
Regency Ballroom

TUESDAY, APRIL 8

7:30 a.m.-11:30 a.m. **REGISTRATION**
Regency Foyer Lobby

8:00 a.m.-11:00 a.m. **BREAKFAST WITH THE HOUSE OF REPRESENTATIVES AND GENERAL SESSION**
Regency A

Chairman-of-the-Day: Virgil Froehlich
Affiliated Foods Cooperative, Inc.
Norfolk, NE

• • •

Topic: "CONGRESS LOOKS AT THE LIABILITY INSURANCE CRISIS"

Speaker:

The Honorable Lowell Weicker (R-CT)
U.S. Senate

• • •

11:00 a.m. **"YOU MAKE THE DIFFERENCE"**
Take advantage of this time to visit your representatives and their staffs to express your views on the issues facing the food distribution industry today. Extra issue papers are available at the registration desk along with suggestions for restaurants to visit for lunch.

5:00 p.m.-6:00 p.m. **RECEPTION**
Regency A
Evening free for dinner

WEDNESDAY, APRIL 9

7:30 a.m.-12:30 p.m. **REGISTRATION**
Regency Foyer Lobby

8:00 a.m.-11:00 a.m. **BREAKFAST WITH THE U.S. SENATE AND GENERAL SESSION**
Regency A

Chairman-of-the-Day: Everett Suddreth
North Carolina Food Dealers
Association
Charlotte, NC

• • •

Topic: "ELECTIONS '86: WHO'S IN? WHO'S OUT?"

Speaker: John Mashek
Chief National Correspondent
U.S. News and World Report

• • •

Topic: "INSURANCE CRISIS: IS THERE A SOLUTION?"

Panelists: Dick Bolger
National Grocers Association

Wayne Smith, Executive Director
United Bus Owners of America

Patrick Hicks
Kentucky Grocers Association

11:00 a.m. Adjournment

99th CONGRESS
United States Senate

(Democrats in roman, Republicans in *italics*)

(Room numbers beginning with SD are in the Dirksen Building, SH are in the Hart Building, and SR are in the Russell Building. Capitol numbers begin with 5)

Name	Phone 224-	Room
Vice Pres. *Bush, George* (Tex.)	42424	SD-202
Abdnor, James (S. Dak.)	42321	SH-309
Andrews, Mark (N. Dak.)	42043	SH-724
Armstrong, William L. (Colo.)	45941	SH-528
Baucus, Max (Mont.)	42651	SH-706
Bentsen, Lloyd (Tex.)	45922	SH-703
Biden, Joseph R., Jr. (Del.)	45042	SR-489
Bingaman, Jeff (N. Mex.)	45521	SH-502
Boren, David L. (Okla.)	44721	SR-453
Boschwitz, Rudy (Minn.)	45641	SH-506
Bradley, Bill (N.J.)	43224	SH-731
Bumpers, Dale (Ark.)	44843	SD-229
Burdick, Quentin N. (N. Dak.)	42551	SH-511
Byrd, Robert C. (W. Va.)	43954	SH-311
Chafee, John H. (R.I.)	42921	SD-567
Chiles, Lawton (Fla.)	45274	SR-250
Cochran, Thad (Miss.)	45054	SR-326
Cohen, William S. (Maine)	42523	SH-322
Cranston, Alan (Calif.)	43553	SH-112
D'Amato, Alfonse M. (N.Y.)	46542	SH-520
Danforth, John C. (Mo.)	46154	SR-497
DeConcini, Dennis (Ariz.)	44521	SH-328
Denton, Jeremiah (Ala.)	45744	SH-516
Dixon, Alan J. (Ill.)	42854	SH-320
Dodd, Christopher J. (Conn.)	42823	SH-324
Dole, Robert (Kans.)	46521	SH-141
Domenici, Pete V. (N.Mex.)	46621	SD-434
Durenberger, Dave (Minn.)	43244	SR-154
Eagleton, Thomas F. (Mo.)	45721	SD-197
East, John P. (N.C.)	43154	SH-716
Evans, Daniel J. (Wash.)	43441	SH-702
Exon, J. James (Nebr.)	44224	SH-330
Ford, Wendell H. (Ky.)	44343	SR173A
Garn, Jake (Utah)	45444	SD-505
Glenn, John (Ohio)	43353	SH-503
Goldwater, Barry (Ariz.)	42235	SR-363

Name	Phone 224-	Room
Gore, Albert, Jr. (Tenn.)	44944	SR-393
Gorton, Slade (Wash.)	42621	SH-513
Gramm, Phil (Tex.)	42934	SR-370
Grassley, Charles E. (Iowa)	43744	SH-135
Harkin, Tom (Iowa)	43254	SH-317
Hart, Gary (Colo.)	45852	SR-237
Hatch, Orrin G. (Utah)	45251	SR-135
Hatfield, Mark O. (Oreg.)	43753	SH-711
Hawkins, Paula (Fla.)	43041	SH-313
Hecht, Chic (Nev.)	46244	SH-302
Heflin, Howell (Ala.)	44124	SH-728
Heinz, John (Pa.)	46324	SR-277
Helms, Jesse (N.C.)	46342	SD-403
Hollings, Ernest F. (S.C.)	46121	SR-125
Humphrey, Gordon J. (N.H.)	42841	SH-531
Inouye, Daniel K. (Hawaii)	43934	SH-722
Johnston, J. Bennett (La.)	45824	SH-136
Kassebaum, Nancy Landon (Kans.)	44774	SR-302
Kasten, Bob (Wis.)	45323	SH-110
Kennedy, Edward M. (Mass.)	44543	SR-113
Kerry, John F. (Mass.)	42742	SR-362
Lautenberg, Frank R. (N.J.)	44744	SH-717
Laxalt, Paul (Nev.)	43542	SR323A
Leahy, Patrick J. (Vt.)	44242	SR-433
Levin, Carl (Mich.)	46221	SR-459
Long, Russell B. (La.)	44623	SR-223
Lugar, Richard G. (Ind.)	44814	SH-306
McClure, James A. (Idaho)	42752	SD-361
McConnell, Mitch (Ky.)	42541	SR-120
Mathias, Charles McC., Jr. (Md.)	44654	SR-387
Matsunaga, Spark M. (Hawaii)	46361	SH-109
Mattingly, Mack (Ga.)	43643	SH-320
Melcher, John (Mont.)	42644	SH-730
Metzenbaum, Howard M. (Ohio)	42315	SR-140
Mitchell, George J. (Maine)	45344	SR-364
Moynihan, Daniel Patrick (N.Y.)	44451	SR-464
Murkowski, Frank H. (Alaska)	46665	SH-709
Nickles, Don (Okla.)	45754	SH-713
Nunn, Sam (Ga.)	43521	SD-303
Packwood, Bob (Oreg.)	45244	SR-259
Pell, Claiborne (R.I.)	44642	SR-335
Pressler, Larry (S. Dak.)	45842	SR407A
Proxmire, William (Wis.)	45653	SD-530
Pryor, David (Ark.)	42353	SR-264

R

Name	Phone 22-	Room
Quayle, Dan (Ind.)	45623	SH-524
Riegle, Donald W., Jr. (Mich.)	44822	SD-105
Rockefeller, John D., IV (W. Va.)	46472	SD-241
Roth, William V., Jr. (Del.)	42441	SH-104
Rudman, Warren (N.H.)	43324	SH-530
Sarbanes, Paul S. (Md.)	44524	SD-332
Sasser, Jim (Tenn.)	43344	SR-298
Simon, Paul (Ill.)	42152	SD-462
Simpson, Alan K. (Wyo.)	43424	SD-261
Specter, Arlen (Pa.)	44254	SH-331
Stafford, Robert T. (Vt.)	45141	SH-133
Stennis, John C. (Miss.)	46253	SR-205
Stevens, Ted (Alaska)	43004	SH-522
Symms, Steven D. (Idaho)	46142	SH-509
Thurmond, Strom (S.C.)	45972	SR-218
Trible, Paul S., Jr. (Va.)	44024	SH-517
Wallop, Malcolm (Wyo.)	46441	SR-206
Warner, John W. (Va.)	42023	SR-421
Weicker, Lowell P., Jr. (Conn.)	44041	SH-303
Wilson, Pete (Calif.)	43841	SH-720
Zorinsky, Edward (Nebr.)	46551	SR-443

99th CONGRESS
United States
House of Representatives

(Democrats in roman; Republicans in *italic*; Resident Commissioner and Delegates in **boldface**)

(Room numbers with 3 digits are in the Cannon HOB, 4 digits beginning with 1 are in the Longworth HOB, 4 digits beginning with 2 are in the Rayburn HOB, digits beginning with H2 are in HOB Annex 2.)

(Capitol room numbers begin with SB, ST, HB, HT with 2 digits and begin with H or S with 3 digits)

Name	Phone 22-	Room
Ackerman, Gary L. (N.Y.)	52601	1725
Addabbo, Joseph P. (N.Y.)	53461	2365
Akaka, Daniel K. (Hawaii)	54906	2301
Alexander, Bill (Ark.)	54076	233
Anderson, Glenn M. (Calif.)	56676	2329
Andrews, Michael A. (Tex.)	57508	1039
Annunzio, Frank (Ill.)	56661	2303
Anthony, Beryl, Jr. (Ark.)	53772	1117
Applegate, Douglas (Ohio)	56265	2464
Archer, Bill (Tex.)	52571	1135
Armey, Richard K. (Tex.)	57772	514
Aspin, Les (Wis.)	53031	442
Atkins, Chester G. (Mass.)	53411	1429
AuCoin, Les (Oreg.)	50855	2159
Badham, Robert E. (Calif.)	55611	2438
Barnard, Doug, Jr. (Ga.)	54101	236
Barnes, Michael D. (Md.)	55341	401
Bartlett, Steve (Tex.)	54201	1709
Barton, Joe (Tex.)	52002	1017
Bateman, Herbert H. (Va.)	54261	1518
Bates, Jim (Calif.)	55452	1404
Bedell, Berkley (Iowa)	55476	2459
Beilenson, Anthony C. (Calif.)	55911	1025
Bennett, Charles E. (Fla.)	52501	2107
Bentley, Helen Delich (Md.)	53061	1610
Bereuter, Doug (Nebr.)	54806	2448

Name	Phone 22⌀	Room
Berman, Howard L. (Calif.)	54695	1221
Bevill, Tom (Ala.)	54876	2302
Biaggi, Mario (N.Y.)	52464	2428
Bilirakis, Michael (Fla.)	55755	1130
Blaz, Ben (Guam)	51188	1729
Bliley, Thomas J., Jr. (Va.)	52815	213
Boehlert, Sherwood L. (N.Y.)	53665	1641
Boggs, Lindy (Mrs. Hale) (La.)	56636	2353
Boland, Edward P. (Mass.)	55601	2426
Boner, William Hill (Tenn.)	54311	107
Bonier, David E. (Mich.)	52106	2242
Bonker, Don (Wash.)	53536	434
Borski, Robert A. (Pa.)	58251	314
Bosco, Douglas H. (Calif.)	53311	408
Boucher, Frederick C. (Va.)	53861	428
Boulter, Beau (Tex.)	53706	1427
Boxer, Barbara (Calif.)	55161	315
Breaux, John B. (La.)	52031	2113
Brooks, Jack (Tex.)	56565	2449
Broomfield, Wm. S. (Mich.)	56135	2306
Brown, George E., Jr. (Calif.)	56161	2256
Brown, Hank (Colo.)	54676	1510
Broyhill, James T. (N.C.)	52576	2340
Bruce, Terry L. (Ill.)	55001	419
Bryant, John (Tex.)	52231	412
Burton, Dan (Ind.)	52276	120
Burton, Sala (Calif.)	54965	1401
Bustamante, Albert G. (Tex.)	34511	1116
Byron, Beverly B. (Md.)	52721	1216
Callahan, Sonny (Ala.)	54931	1631
Campbell, Carroll A., Jr. (S.C.)	56030	106
Carney, William (N.Y.)	53826	1424
Carper, Thomas R. (Del.)	54165	1020
Carr, Bob (Mich.)	54872	2439
Chandler, Rod (Wash.)	57761	216
Chapman, Jim (Tex.)	53035	1009
Chappell, Bill, Jr. (Fla.)	54035	2468
Chappie, Gene (Calif.)	53076	1730
Cheney, Dick (Wyo.)	52311	225
Clay, William (Bill) (Mo.)	52406	2470
Clinger, William F., Jr. (Pa.)	55121	1122
Coats, Dan (Ind.)	54436	1417
Cobey, William W., Jr. (N.C.)	51784	510
Coble, Howard (N.C.)	53065	513

Name	Phone 22⌀	Room
Coelho, Tony (Calif.)	56131	403
Coleman, E. Thomas (Mo.)	57041	2344
Coleman, Ronald D. (Tex.)	54831	416
Collins, Cardiss (Ill.)	55006	2264
Combest, Larry (Tex.)	54005	1529
Conte, Silvio O. (Mass.)	55335	2300
Conyers, John, Jr. (Mich.)	55126	2313
Cooper, Jim (Tenn.)	56831	125
Coughlin, Lawrence (Pa.)	56111	2467
Courter, Jim (N.J.)	55801	2422
Coyne, William J. (Pa.)	52301	424
Craig, Larry E. (Idaho)	56611	1318
Crane, Philip M. (Ill.)	53711	1035
Crockett, Geo. W., Jr. (Mich.)	52261	1531
Daniel, Dan (Va.)	54711	2308
Dannemeyer, William E. (Calif.)	54111	1214
Darden, George (Buddy) (Ga.)	52931	1330
Daschle, Thomas A. (S. Dak.)	52801	2455
Daub, Hal (Nebr.)	54155	1019
Davis, Robert W. (Mich.)	54735	1124
de la Garza, E. (Tex.)	52531	1401
DeLay, Tom (Tex.)	55951	1234
Dellums, Ronald V. (Calif.)	52661	2136
de Lugo, Ron (V.I.)	51790	2238
Derrick, Butler (S.C.)	56301	201
DeWine, Michael (Ohio)	54324	1519
Dickinson, William L. (Ala.)	52901	2406
Dicks, Norman D. (Wash.)	55916	2429
Dingell, John D. (Mich.)	54071	2221
DioGuardi, Joseph J. (N.Y.)	56506	1630
Dixon, Julian C. (Calif.)	57084	2400
Donnelly, Brian J. (Mass.)	53215	438
Dorgan, Byron L. (N. Dak.)	52611	238
Dornan, Robert K. (Calif.)	52965	301
Dowdy, Wayne (Miss.)	55865	214
Downey, Thomas J. (N.Y.)	53535	2232
Dreier, David (Calif.)	52305	410
Duncan, John J. (Tenn.)	58435	2206
Durbin, Richard J. (Ill.)	55271	417
Dwyer, Bernard J. (N.J.)	56301	404
Dymally, Mervyn M. (Calif.)	55425	1717
Dyson, Roy (Md.)	55311	224
Early, Joseph D. (Mass.)	56101	2349
Eckart, Dennis E. (Ohio)	56331	1224
Eckert, Fred J. (N.Y.)	53615	427

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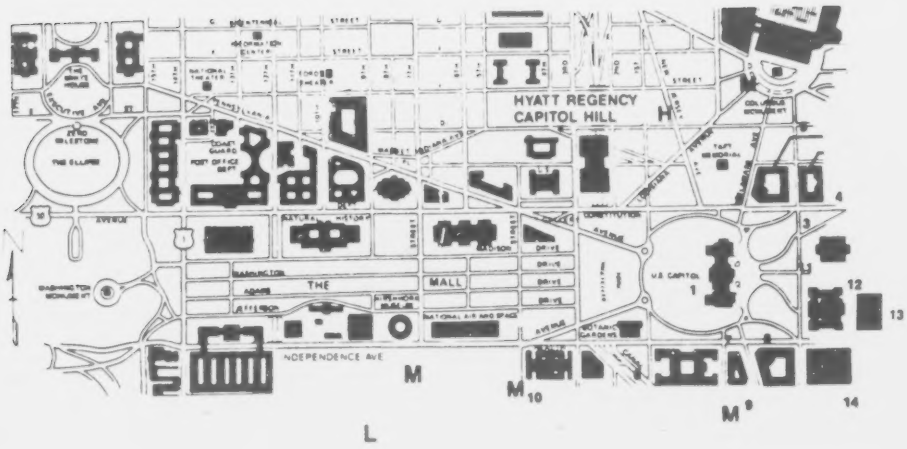

MAP OF THE HILL

1. U.S. Capitol Building
2. Russell Senate Office Building
3. Dirksen Senate Office Building
4. Hart Senate Office Building
5. Senate Annexes
6. Rayburn House Office Building
7. Longworth House Office Building
8. Cannon House Office Building
9. House Annex No. 1
10. House Annex No. 2
11. U.S. Supreme Court
12. Library of Congress—
    Thomas Jefferson Building
13. Library of Congress—
    John Adams Building
14. Library of Congress—
    James Madison Building

M Metrorail Entrances

H Hyatt Regency Hotel Capitol Hill—
400 New Jersey Ave., N.W.

- **Registrants are advised to use entrances to House Office Buildings from Independence Avenue.**
- **Entrance to Senate Office Buildings should be made from Constitution Avenue.**

Name	Phone 22∅	Room
Edgar, Bob (Pa.)	52011	2352
Edwards, Don (Calif.)	53072	2307
Edwards, Mickey (Okla.)	52132	2434
Emerson, Bill (Mo.)	54404	418
English, Glenn (Okla.)	55565	2235
Erdreich, Ben (Ala.)	54921	439
Evans, Cooper (Iowa)	53301	127
Evans, Lane (Ill.)	55605	328
Fascell, Dante B. (Fla.)	54506	2354
Fauntroy, Walter E. (D.C.)	56050	2135
Fawell, Harris W. (Ill.)	53515	511
Fazio, Vic (Calif.)	55716	1421
Feighan, Edward F. (Ohio)	55731	1223
Fiedler, Bobbi (Calif.)	55811	1607
Fields, Jack (Tex.)	54901	413
Fish, Hamilton, Jr. (N.Y.)	55441	2227
Flippo, Ronnie G. (Ala.)	54801	2334
Florio, James J. (N.J.)	56501	2162
Foglietta, Thomas M. (Pa.)	54731	1217
Foley, Thomas S. (Wash.)	52006	1201
Ford, Harold E. (Tenn.)	53265	2305
Ford, William D. (Mich.)	56261	239
Fowler, Wyche, Jr. (Ga.)	53801	1210
Frank, Barney (Mass.)	55931	1030
Franklin, Webb (Miss.)	55876	124
Frenzel, Bill (Minn.)	52871	1026
Frost, Martin (Tex.)	53605	1238
Fuqua, Don (Fla.)	55155	2269
Fuster, Jaime B. (P.R.)	52615	1428
Gallo, Dean A. (N.J.)	55034	1724
Garcia, Robert (N.Y.)	54361	223
Gaydos, Joseph M. (Pa.)	54631	2186
Gejdenson, Sam (Conn.)	52076	1410
Gekas, George W. (Pa.)	54315	1008
Gephardt, Richard A. (Mo.)	52671	1432
Gibbons, Sam (Fla.)	53376	2204
Gilman, Benjamin A. (N.Y.)	53776	2160
Gingrich, Newt (Ga.)	54501	1005
Glickman, Dan (Kans.)	56216	2435
Gonzalez, Henry B. (Tex.)	53236	2413
Goodling, William F. (Pa.)	55836	2263
Gordon, Bart (Tenn.)	54231	1517
Gradison, Willis D., Jr. (Ohio)	53164	2311
Gray, Kenneth J. (Ill.)	55201	2109

Name	Phone 22∅	Room
Gray, William H., III (Pa.)	54001	204
Green, Bill (N.Y.)	52436	1110
Gregg, Judd (N.H.)	55206	308
Grotberg, John E. (Ill.)	52976	515
Guarini, Frank J. (N.J.)	52765	2458
Gunderson, Steve (Wis.)	55506	227
Hall, Ralph M. (Tex.)	56673	1728
Hall, Tony P. (Ohio)	56465	2448
Hamilton, Lee H. (Ind.)	55315	2187
Hammerschmidt, John Paul (Ark.)	54301	2207
Hansen, James V. (Utah)	50453	1113
Hartnett, Thomas F. (S.C.)	53176	228
Hatcher, Charles (Ga.)	53631	405
Hawkins, Augustus F. (Calif.)	52201	2371
Hayes, Charles A. (Ill.)	54372	1028
Hefner, W. G. (Bill) (N.C.)	53715	2161
Heftel, Cecil (Cec) (Hawaii)	52726	1034
Hendon, William M. (N.C.)	56401	115
Henry, Paul B. (Mich.)	53851	502
Hertel, Dennis M. (Mich.)	56276	218
Hiler, John (Ind.)	53915	407
Hillis, Elwood (Ind.)	55037	2336
Holt, Marjorie S. (Md.)	56090	2412
Hopkins, Larry J. (Ky.)	54706	331
Horton, Frank (N.Y.)	54916	2229
Howard, James J. (N.J.)	54671	2245
Hoyer, Steny H. (Md.)	54131	1513
Hubbard, Carroll, Jr. (Ky.)	55115	2182
Huckaby, Jerry (La.)	52376	2421
Hughes, William J. (N.J.)	56572	341
Hunter, Duncan (Calif.)	55672	117
Hutto, Earl (Fla.)	54136	330
Hyde, Henry J. (Ill.)	54561	2104
Ireland, Andy (Fla.)	55015	2416
Jacobs, Andrew, Jr. (Ind.)	54011	1533
Jeffords, James M. (Vt.)	54115	2431
Jenkins, Ed (Ga.)	55211	217
Johnson, Nancy L. (Conn.)	54476	119
Jones, Ed (Tenn.)	54714	108
Jones, James R. (Okla.)	52211	203
Jones, Walter B. (N.C.)	55101	241
Kanjorski, Paul E. (Pa.)	56511	1711
Kaptur, Marcy (Ohio)	54146	1228

Name	Phone 22-	Room
Kasich, John R. (Ohio)	55355	1133
Kastenmeier, Robert W. (Wis.)	52906	2328
Kemp, Jack F. (N.Y.)	55265	2252
Kennelly, Barbara B. (Conn.)	52265	1230
Kildee, Dale E. (Mich.)	53611	2432
Kindness, Thomas N. (Ohio)	56205	2417
Kleczka, Gerald D. (Wis.)	54572	226
Kolbe, Jim (Ariz.)	52542	1222
Kolter, Joe (Pa.)	52565	212
Kostmayer, Peter H. (Pa.)	54276	123
Kramer, Ken (Colo.)	54422	240
LaFalce, John J. (N.Y.)	53231	2419
Lagomarsino, Robert J. (Calif.)	53601	2332
Lantos, Tom (Calif.)	53531	1707
Latta, Delbert L. (Ohio)	56405	2309
Leach, Jim (Iowa)	56576	1514
Leath, Marvin (Tex.)	56105	336
Lehman, Richard H. (Calif.)	54540	1319
Lehman, William (Fla.)	54211	2347
Leland, Mickey (Tex.)	53816	2236
Lent, Norman F. (N.Y.)	57896	2408
Levin, Sander M. (Mich.)	54961	323
Levine, Mel (Calif.)	56451	132
Lewis, Jerry (Calif.)	55861	326
Lewis, Tom (Fla.)	55792	1313
Lightfoot, Jim (Iowa)	53806	1609
Lipinski, William O. (Ill.)	55701	1032
Livingston, Bob (La.)	53015	2437
Lloyd, Marilyn (Tenn.)	53271	2266
Loeffler, Tom (Tex.)	54236	1212
Long, Cathy (Mrs. Gillis) (La.)	54926	1338
Lott, Trent (Miss.)	55772	2185
Lowery, Bill (Calif.)	53201	1440
Lowry, Mike (Wash.)	53106	2454
Lujan, Manuel, Jr. (N. Mex.)	56316	1323
Luken, Thomas A. (Ohio)	52216	2368
Lundine, Stan (N.Y.)	53161	2427
Lungren, Dan (Calif.)	52415	2440
McCain, John (Ariz.)	52635	1123
McCandless, Alfred A. (Al) (Calif.)	55330	435
McCloskey, Frank (Ind.)	54636	116
McCollum, Bill (Fla.)	52176	1507
McCurdy, Dave (Okla.)	56165	313
McDade, Joseph M. (Pa.)	53731	2370

Name	Phone 22-	Room
McEwen, Bob (Ohio)	55705	329
McGrath, Raymond J. (N.Y.)	55516	205
McHugh, Matthew F. (N.Y.)	56335	2335
McKernan, John R., Jr. (Maine)	56116	1535
McKinney, Stewart B. (Conn.)	55541	237
McMillan, J. Alex (N.C.)	51976	507
Mack, Connie (Fla.)	52536	504
MacKay, Buddy (Fla.)	55744	503
Madigan, Edward R. (Ill.)	52371	2312
Manton, Thomas J. (N.Y.)	53965	327
Markey, Edward J. (Mass.)	52836	2133
Marlenee, Ron (Mont.)	51555	409
Martin, David O'B. (N.Y.)	54611	109
Martin, Lynn (Ill.)	55676	1208
Martinez, Matthew G. (Calif.)	55464	430
Matsui, Robert T. (Calif.)	57163	231
Mavroules, Nicholas (Mass.)	58020	440
Mazzoli, Romano L. (Ky.)	55401	2246
Meyers, Jan (Kans.)	52865	1407
Mica, Dan (Fla.)	53001	131
Michel, Robert H. (Ill.)	56201	2112
Mikulski, Barbara A. (Md.)	54016	2404
Miller, Clarence E. (Ohio)	55131	2208
Miller, George (Calif.)	52095	2228
Miller, John R. (Wash.)	58311	1723
Mineta, Norman Y. (Calif.)	52631	2350
Mitchell, Parren J. (Md.)	54741	2367
Moakley, Joe (Mass.)	58279	221
Molinari, Guy V. (N.Y.)	53371	208
Mollohan, Alan B. (W. Va.)	54172	516
Monson, David S. (Utah)	53011	1022
Montgomery, G. V. (Sonny) (Miss.)	55031	2184
Moody, Jim (Wis.)	53571	1721
Moore, W. Henson (La.)	53901	2183
Moorhead, Carlos J. (Calif.)	54176	2346
Morrison, Bruce A. (Conn.)	53661	437
Morrison, Sid (Wash.)	55816	1434
Mrazek, Robert J. (N.Y.)	55956	306
Murphy, Austin J. (Pa.)	54665	2210
Murtha, John P. (Pa.)	52065	2423
Myers, John T. (Ind.)	55805	2372
Natcher, William H. (Ky.)	53501	2333
Neal, Stephen L. (N.C.)	52071	2463
Nelson, Bill (Fla.)	53671	307
Nichols, Bill (Ala.)	52261	2405

Name	Phone 22#	Room
Rouland, John G. (Conn.)	53822	512
Roybal, Edward R. (Calif.)	56235	2211
Rudd, Eldon (Ariz.)	53361	2465
Russo, Marty (Ill.)	55736	2233
Sabo, Martin Olav (Minn.)	54755	436
St Germain, Fernand J. (R.I.)	54911	2108
Savage, Gus (Ill.)	50773	1121
Saxton, Jim (N.J.)	54765	509
Schaefer, Dan (Colo.)	57882	1317
Scheuer, James H. (N.Y.)	55471	2402
Schneider, Claudine (R.I.)	52735	1512
Schroeder, Patricia (Colo.)	54431	2410
Schuette, Bill (Mich.)	53561	415
Schulze, Richard T. (Pa.)	55761	2201
Schumer, Charles E. (N.Y.)	56616	126
Seiberling, John F. (Ohio)	55231	1225
Sensenbrenner, F. James, Jr. (Wis.)	55101	2444
Sharp, Philip R. (Ind.)	53021	2452
Shaw, E. Clay, Jr. (Fla.)	53026	322
Shelby, Richard C. (Ala.)	52065	2443
Shumway, Norman D. (Calif.)	52511	1203
Shuster, Bud (Pa.)	52431	2268
Sikorski, Gerry (Minn.)	52271	414
Siljander, Mark D. (Mich.)	53761	137
Sisisky, Norman (Va.)	56365	426
Skeen, Joe (N. Mex.)	52365	1007
Skelton, Ike (Mo.)	52876	2453
Slattery, Jim (Kans.)	56601	1431
Slaughter, D. French, Jr. (Va.)	56561	319
Smith, Christopher H. (N.J.)	53765	422
Smith, Denny (Oreg.)	55711	1213
Smith, Lawrence J. (Fla.)	57931	113
Smith, Neal (Iowa)	54426	2373
Smith, Robert C. (N.H.)	55456	506
Smith, Robert F. (Bob) (Oreg.)	56730	118
Smith, Virginia (Nebr.)	56435	2202
Snowe, Olympia J. (Maine)	56306	133
Snyder, Gene (Ky.)	53465	2188
Solarz, Stephen J. (N.Y.)	52361	1536
Solomon, Gerald B. H. (N.Y.)	55614	2342
Spence, Floyd (S.C.)	52452	2466
Spratt, John M., Jr. (S.C.)	55501	1118
Staggers, Harley O., Jr. (W. Va.)	54331	1504
Stallings, Richard H. (Idaho)	55531	1233

Name	Phone 22#	Room
Stangeland, Arlan (Minn.)	57751	1229
Stark, Fortney H. (Pete) (Calif.)	53306	2240
Stenholm, Charles W. (Tex.)	55871	2436
Stokes, Louis (Ohio)	56211	2351
Strang, Gerald (Ohio)	53365	2217
Studds, Gerry E. (Mass.)	53635	2369
Stump, Bob (Ariz.)	55431	1207
Sundquist, Don (Tenn.)	55111	2231
Swift, Al (Wash.)	57742	1524
Swindall, Patrick L. (Ga.)	56231	114
Synar, Mike (Okla.)	52676	1108
Tallon, Robin (S.C.)	53906	316
Tauke, Tom (Iowa)	52861	339
Taylor, Gene (Miss.)	54376	1705
Thomas, Lindy (Ga.)	53341	129
Thomas, Pat (Fla.)	53401	1127
Torres, Esteban E. (Calif.)	52472	501
Torricelli, Robert G. (N.J.)	53931	2239
Towns, Edolphus (N.Y.)	54935	1004
Traficant, James A., Jr. (Ohio)	52476	1024
Udall, Mo (Ariz.)	54865	242
Upton, Fred (Mich.)	54835	1131
Valentine, Tim (N.C.)	55661	2110
Vander Jagt, Guy (Mich.)	54401	1414
Vento, Bruce F. (Minn.)	55355	2446
Visclosky, Peter J. (Ind.)	56356	102
Volkmer, Harold L. (Mo.)	53476	2411
Walgren, Doug (Pa.)	53452	343
Walker, Robert S. (Pa.)	54365	2330
Watkins, Wesley W. (Okla.)	55901	425
Waxman, Henry A. (Calif.)	53876	2209
Weaver, James (Oreg.)	55965	1530
Weber, Vin (Minn.)	56190	325
Whitehurst, G. William (Va.)	55406	1714
Whitley, Charles (N.C.)	55361	2338
Wilson, Charles (Tex.)	56411	2447
Wirth, Timothy E. (Colo.)	52715	1314
Wise, Robert E., Jr. (W. Va.)	52506	1541
Wolf, Frank R. (Va.)	53436	2462
Wortley, George C. (N.Y.)	55751	2243
Wright, Jim (Tex.)	52777	103
Wyden, Ron (Oreg.)	54601	206
Yates, Sidney R. (Ill.)	52731	2230
Yatron, Gus (Pa.)	54061	2111
Young, Bill (Fla.)	55665	215
Young, C. W. Bill (Fla.)	54465	303
Young, Don (Alaska)	56531	423

Name	Phone 224	Room
Stangeland, Arlan (Minn.)	52165	1526
Stark, Fortney H. (Pete) (Calif.)	55065	1125
Stenholm, Charles W. (Tex.)	56605	1232
Stokes, Louis (Ohio)	57032	2304
Strang, Michael L. (Colo.)	54761	1331
Stratton, Samuel S. (N.Y.)	55076	2205
Studds, Gerry E. (Mass.)	53111	1501
Stump, Bob (Ariz.)	54576	211
Sundquist, Don (Tenn.)	52811	230
Sunia, Fofo I. F. (Am. Samoa)	58577	1206
Sweeney, Mac (Tex.)	52831	1713
Swift, Al (Wash.)	52605	1502
Swindall, Patrick L. (Ga.)	54272	508
Synar, Mike (Okla.)	52701	2441
Tallon, Robin (S.C.)	53315	432
Tauke, Thomas J. (Iowa)	52911	2244
Tauzin, W. J. (Billy) (La.)	54031	222
Taylor, Gene (Mo.)	56536	2134
Thomas, Robert Lindsay (Ga.)	55831	431
Thomas, William M. (Calif.)	52915	324
Torres, Esteban Edward (Calif.)	55256	1740
Torricelli, Robert G. (N.J.)	55061	317
Towns, Edolphus (N.Y.)	53936	1726
Traficant, James A., Jr. (Ohio)	55261	128
Traxler, Bob (Mich.)	52506	2366
Udall, Morris K. (Ariz.)	54065	235
Valentine, Tim (N.C.)	54531	1107
Vander Jagt, Guy (Mich.)	53511	2409
Vento, Bruce F. (Minn.)	56631	2433
Visclosky, Peter J. (Ind.)	52461	1632
Volkmer, Harold L. (Mo.)	52956	2411
Vucanovich, Barbara F. (Nev.)	56155	312
Walgren, Doug (Pa.)	52135	2241
Walker, Robert S. (Pa.)	52411	2445
Watkins, Wes (Okla.)	54585	2348
Waxman, Henry A. (Calif.)	53976	2418
Weaver, James (Oreg.)	56416	1226
Weber, Vin (Minn.)	52331	318
Weiss, Ted (N.Y.)	55635	2442
Wheat, Alan (Mo.)	54535	1204
Whitehurst, G. William (Va.)	54215	2469
Whitley, Charles (N.C.)	53415	104
Whittaker, Bob (Kans.)	53911	332
Whitten, Jamie L. (Miss.)	54306	2314

Name	Phone 224	Room
Williams, Pat (Mont.)	53211	2457
Wilson, Charles (Tex.)	52401	2265
Wirth, Timothy E. (Colo.)	52161	2262
Wise, Robert E., Jr. (W. Va.)	52711	1508
Wolf, Frank R. (Va.)	55136	120
Wolpe, Howard (Mich.)	55011	1527
Wortley, George C. (N.Y.)	53701	229
Wright, Jim (Tex.)	55071	1236
Wyden, Ron (Oreg.)	54811	1406
Wylie, Chalmers P. (Ohio)	52015	2310
Yates, Sidney R. (Ill.)	52111	2234
Yatron, Gus (Pa.)	55546	2267
Young, C. W. Bill (Fla.)	55961	2407
Young, Don (Alaska)	55765	2331
Young, Robert A. (Mo.)	52561	2430
Zschau, Ed (Calif.)	55411	429

Office for 8th Dist. of Ind.	54636	116

Y

National Grocers Association

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Controller

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AA

NATIONAL
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1825 Samuel Morse Drive
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BB

ACCOUNT	TYP	ACCTG	ENTRY	VOUCHER	VENDOR	PO #	REFERENCE	CHECK #	AMOUNT	PAYEE - DESCRIPTION
51100301										
# EXEC VP PUBLIC AFFRS CONF, ADVERTISING									0.00	
51120301										
### EXEC VP PUBLIC AFFRS CONF, MAILING LIST#									0.00	
51200301										
### EXEC VP PUBLIC AFFRS CONF, PROMOTION									0.00	
52000301	APJ	03/26/86	03/26	13957	1947		02390-10		2,000.00	SPEAKER HONORIA
52000301	APD	03/27/86	04/10	14085	1947		02409-10		1,000.00	SPEAKER HONORIA
52000301	APD	03/27/86	04/10	14087	1947		02409-11		750.00	SPEAKER HONORIA
52000301	APD	03/27/86	04/10	14088	1947		02409-12		500.00	SPEAKER HONORIA
### EXEC VP PUBLIC AFFRS CONF, SPEAKERS HONORARIA									4,250.00	
52020301										
### EXEC VP PUBLIC AFFRS CONF, AIR TRANSPORTATION									0.00	
52030301										
### EXEC VP PUBLIC AFFRS CONF, LODGING									0.00	
52040301	APD	05/07/86	05/27	14359	[illegible]		02599-2		64.85	SPEAKER OTHER
### EXEC VP PUBLIC AFFRS CONF, GROUND TRANSPORT[illegible]									64.85	
52200301										
### EXEC VP PUBLIC AFFRS CONF, SPOUSE PROGRAM									0.00	
52210301										
### EXEC VP PUBLIC AFFRS CONF, YOUTH PROGRAM									0.00	
53090301										
### EXEC VP PUBLIC AFFRS CONF, TEMPORARY HELP									0.00	
54000301										
### EXEC VP PUBLIC AFFRS CONF, RENT									0.00	
54100301										
### EXEC VP PUBLIC AFFRS CONF, SECURITY									0.00	

CC

SPECIAL
COUNSEL
HEARING
EX. 170

A

Call Gries -

Wed. Thurs. Fri
2/27-28
3/1

Miami speech

POWERS PYLES SUTTER & O'HARE
ATTORNEYS AT LAW
SUITE 750
1800 CONNECTICUT AVENUE, N. W.
WASHINGTON, D. C. 20009

TELEPHONE
202 466-6550
202 296-9243

GALEN D. POWERS
JAMES C. PYLES *
RONALD N. SUTTER
PATRICK K. O'HARE
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JOHN J. MILES
DIANE S. MILLMAN
ANN HASTINGS SWETT
MARK R. FITZGERALD

*MEMBER OF TENNESSEE AND MARYLAND BARS

November 8, 1984

OK

The Honorable Dave Durenberger
Russell Senate Office Building
Constitution Avenue, between
Delaware Avenue and First Street, N.E.
Washington, D.C. 20510

Dear Senator Durenberger:

The purpose of this letter is to invite you to be the luncheon speaker at a program on Capital Finance for Health Care Facilities that will be sponsored by the National Health Lawyers Association and held in Miami on February 27 and 28, and March 1, 1985.

The National Health Lawyers Association has about 3000 members and throughout the year sponsors educational programs on topics of interest to lawyers in the health care field. We anticipate, based on our experience last year when Congressman Gradison was the luncheon speaker, that about 200 people will enroll for the seminar. The audience will be composed of investment bankers, personnel from bond issuing authorities, chief executives and chief financial officers of hospitals and other health care institutions, lawyers representing those institutions, bond counsel, and underwriters' counsel.

This audience would be keenly interested in hearing your views on Congressional considerations in changing to a new capital payment system under Medicare.

Could speech 265 P+P

We would be pleased to have you speak at lunch on Friday, March 1, so that you would probably not miss a legislative day. You would be the only speaker from the Congress. In addition to reimbursing your expenses, we would be pleased to provide a $1,000.00 honorarium. We know you have a very busy schedule, but would hope that you could devote about 30 minutes to prepared remarks and another 10 to 15 minutes to questions from the audience.

01

for DO + PD

They will pick up tab through weekend & anything else you can need.

POWERS, PYLES, SUTTER & O'HARE

The Honorable Dave Durenberger
November 8, 1984
Page 2

Please let me know if there is any other information that I can furnish you. We hope to receive an early and favorable response.

Sincerely,

Galen D. Powers

GDP/dj

B

POWERS, PYLES, SUTTER & O'HARE
ATTORNEYS AT LAW
SUITE 730
1100 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036

GALEN D. POWERS
JAMES C. PYLES*
RONALD N. SUTTER
PATRICK E. O'HARE
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JOHN J. MILES
ANN HASTINGS SWETT
MARK B. FITZGERALD

*MEMBER MARYLAND AND TENNESSEE BARS ONLY

TELEPHONE
202/466-6550
202/296-9243

November 27, 1984

Jeanie Johnson
Director of Programs
National Health Lawyers Association
522 - 21st Street, N.W.
Suite 120
Washington, D.C. 20006

Re: Expenses for Capital Finance Seminar

Dear Jeanie:

I have made three "out of the ordinary" expense arrangements for this seminar.

✓1. I agreed to have reimbursed for coach air fare.

✓2. I agreed to have reimbursed for coach air fare.

3. I offered to pay Senator Durenberger a ~~$2,000.00~~ $1000 honorarium and also to pick up his expenses (and his wife's), including through the weekend if he decides to stay.

Thanks for your help.

Sincerely,

Galen Powers

GDP/dj

C

Durenberger

POWERS, PYLES, SUTTER & O'HARE

ATTORNEYS AT LAW
SUITE 730
1100 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036

DALEN C. POWERS
JAMES C. PYLES*
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TELEPHONE
(202) 466-6550
(202) 296-9241

March 26, 1985

A 3.29.85
3221
$ 716.00

Ms. Jeanie Johnson
Director of Programs
National Health Lawyers Association
522 21st Street, N.W.
Suite 120
Washington, D.C. 20006

Dear Jeanie:

Please find attached the travel invoice in the amount of $716.00 (the cost of coach roundtrip airfare) for Senator Durenberger's trip to Miami on March 1, 1985, to attend the 1985 NHLA Capital Finance and Joint Venture Seminar. Please make your check payable to Powers, Pyles, Sutter & O'Hare.

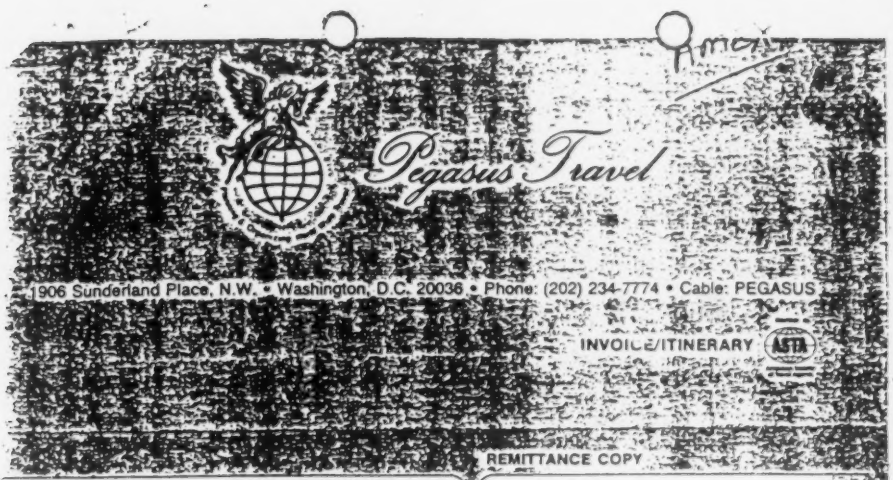
Sincerely,

Lanii Benston
Administrator

LB/dj

Enclosure

D



Pegasus Travel

1906 Sunderland Place, N.W. • Washington, D.C. 20036 • Phone: (202) 234-7774 • Cable: PEGASUS

INVOICE/ITINERARY ASTA

REMITTANCE COPY

RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS AND SUGGEST 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS
CAUTION: TICKETS HAVE VALUE IF UNUSED. PLEASE RETURN FOR CREDIT OR REFUND

2584

DURENBERGER/DAVE SEN

POWERS PYLES SUTTER AND OHARE
1100 CONN AVE NW
WASHINGTON DC 20036
SUITE 730

DATE: FEB 26 1985 2584

AIRLINE	FLIGHT	CL	DATE	FROM	TO	DEPARTS	ARRIVES	STAT
ASTERN	195	F	1MAR	WAS NATIONAL	MIAMI FLA.	830A	1049A	OK
SEAT 2B			FRI 72S NONSTOP		BREAKFAST			
ASTERN	546	F	1MAR	MIAMI FLA.	TAMPA/STPETERS	230P	324P	RQ
			FRI 72S NONSTOP					
URFACE			SURFACE		SURFACE			
ORTHWEST	70	F	3MAR	MPLS/ST PAUL	WAS NATIONAL	605P	915P	OK
			SUN 72S NONSTOP		DINNER			

AIR FARE 662.97 TAX 53.03 TOTAL 716.00

NVOICE NUMBER 2584 TOTAL INVOICE $716.00
AYMENT - AGENTCHECK

URENBERGER/DAVE SEN TICKET 0077733568674
HARGE ACCOUNT--NHLA

TICKETED IN FIRST CLASS*

A546 for FIRST CLASS is highest priority waitlist, CONFIRMED SPACE on EA546 is in oach class--SEAT 12D

*70-A non-smoking aisle seat has been requested

POWERS, PYLES, SUTTER & O'HARE

ATTORNEYS AT LAW
SUITE 730
1100 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036

TELEPHONE
(202) 466-6550
(202) 296-9243

GALEN D. POWERS
JAMES C. PYLES*
RONALD N. SUTTER
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GUY COLLIER
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MARY SUSAN PHILP
ANN HASTINGS SWETT
MARK B. FITZGERALD
DAVID C. BECK**

*MEMBER MARYLAND AND TENNESSEE BARS ONLY
**MEMBER MASSACHUSETTS BAR ONLY

Pd 3.29.85
H 3267
1000.00

March 26, 1985

Ms. Jeanie Johnson
Director of Programs
National Health Lawyers Association
522 21st Street, N.W.
Suite 120
Washington, D.C. 20006

Re: Capital Finance and Joint Ventures Seminar

Dear Jeanie:

An honorarium of $1,000.00 should be paid for Senator Durenburger's speech to:

Piranha Press
4504 Excelsior Boulevard
Minneapolis, Minnesota 55416

The check should be sent to the attention of Gary Diamond.

Thanks for your assistance.

Sincerely,

Galen D. Powers

GDP/dj

F

No. 3271

March 24 19 85

PAY TO Powers, Pyles, Sutter & O'Hare

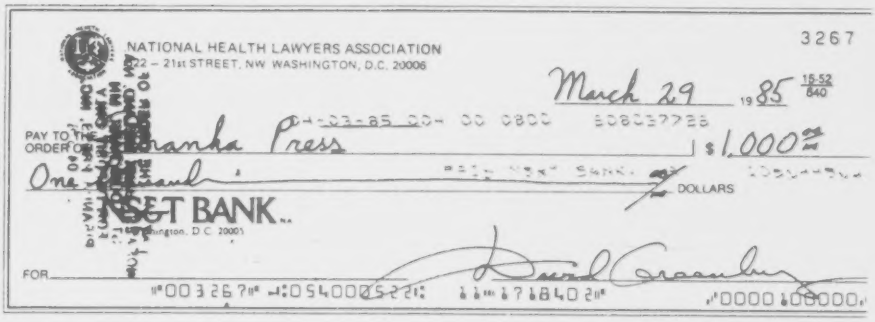
FOR Durrenberger's Air Travel

DEPOSIT Faculty Air Travel

COST 910 - 656

		BALANCE	
		AMOUNT THIS CHECK	716 00
		BALANCE	92508 12

HARLAND - 2



NATIONAL HEALTH LAWYERS ASSOCIATION
122 – 21st STREET, NW WASHINGTON, D.C. 20006

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March 29 1985 15-52/840

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One thousand and no/100 DOLLARS

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Federation of American Hospitals
Michael D. Bromberg, Esquire, Executive Director

National Offices 1111 19th Street, N.W., Suite 402
Washington, D.C. 20036 Telephone 202/833-3090

January 4, 1985

The Honorable David Durenberger
375 Russell Senate Office Building
Washington, D. C. 20510

Dear Dave:

As a member of the Executive Committee of the National Health Lawyers Association, I would like to invite you to address the NHLA Annual "Health Law Update." The meeting will be held in Washington, D.C., at the J. W. Marriott Hotel (1331 Penn. Avenue, N.W.) on May 6, 1985.

We would like you to present your views on "Health Legislation and the 99th Congress" to an audience of about 300 health attorneys from across the nation. This session is scheduled for 10:45 a.m. on May 6th and will last approximately 30 minutes.

The membership of the National Health Lawyers Association has grown to over 3,500 and the Annual Meeting in Washington highlights the educational activities of this 501(c)(3) organization. Your participation would be appreciated and we hope you will be able to accept this invitation.

Sincerely,

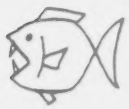
Michael D. Bromberg

MDB:rt
cc: David Greenburg
Executive Director
National Health Lawyers Association

Dave - Hope you can do this
It's a good group -
Regards
Mike

SPECIAL
COUNSEL
HEARING
EX. 171
A

PIRANHA



PRESS

Gary L. Diamond
Publisher

April 4, 1985

Mr. Michael D. Bromberg
Executive Director
Federation of American Hospitals
1111 19th Street NW
Suite 402
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Bromberg:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Health Lawyers Association in the near future.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book, Neither Madmen Nor Messiahs, and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book. It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

B

Because Senator Durenberger's appearance before your organization will be in promotion of Neither Madmen Nor Messiahs, we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

C

NATIONAL HEALTH LAWYERS ASSOCIATION
APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
May 7, 1985	10:45-11:15 a.m.	Washington, DC	$1,000

D

FROM THE DESK OF

Michael D. Bromberg, Esq.

4/15/85

David —

Sounds unusual but it's what he's been doing. If you have a problem please let me know.

Mike

MB/ 833-3090

RGER

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consideration of the
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or making all travel
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ckets delivered to his
scheduled departure.

All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

Federation of American Hospitals
1111 19th Street, N.W.
Suite 402
Washington, D.C. 20036
202-833-3090

E

NATIONAL HEALTH LAWYERS ASSOCIATION

522 21st Street, N.W., Suite 120
Washington, D.C. 20006
(202) 833-1100

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Maxicare Health Plans, Inc
Hawthorne, California
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Blue Cross & Blue Shield Plan of Florida
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Newport Beach, California
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Wood, Lucksinger & Epstein
Cripple Creek, Colorado

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JOSEPH A. MURPHY, JR., ESQ
MICHAEL J. TICHON, ESQ
EXECUTIVE DIRECTOR:
DAVID J. GREENBURG, ESQ

April 24, 1985

pd. 4/23/85
CR #3362
$1,000.00

Gary Diamond, President
Piranha Press
4504 Excelsior Boulevard
Minneapolis, MN 55416

Dear Mr. Diamond:

Michael Bromberg, Executive Director of the Federation of American Hospitals, passed on your letter to me confirming Senator Durenberger's presentation at our Health Law Update and Annual Meeting on May 7, 1985. You might note, however, that the Senator is scheduled to speak before our group between 12noon and 1:45pm rather than the time you indicated in your letter. Anne Kelly is aware of the correct time slot.

Per your request, we will provide a table for display for the Senator's upcoming publication. Also, I have enclosed a check for $1,000.00 to cover the Senator's honorarium.

Thank you for your assistance and cooperation. Don't hesitate to call if you have any questions.

Sincerely,

Jeanie M. Johnson

Jeanie M. Johnson
Director of Programs

JMJ:pc
Enclosure

F

NATIONAL HEALTH LAWYERS ASSOCIATION

PRESS RELEASE

FOR IMMEDIATE RELEASE:

Press Contact: Jaime Doherty
(202) 833-1100

Two prominent Congressional leaders will be addressing the status of current and future federal health legislation and other issues facing the health care industry at the 1985 Health Law Update and annual meeting of the National Health Lawyers Association, to be held May 5-7, 1985 in Washington D.C. Representative Robert T. Matsui (D-CA) will be addressing the immediate future of health legislation during a legislative update session on May 6, given in conjunction with Michael D. Bromberg, Executive Director of the Federation of American Hospitals. Senator David F. Durenberger (R-MN), Chairman of the Senate Finance Subcommittee on Health, will be the featured luncheon speaker on Tuesday, May 7.

In addition, other speakers at the seminar will provide an indepth review of the various legal developments that have emerged in the health care field over the past year. The program will begin

on Sunday, May 5 with the popular Introductory Course on health law which will provide valuable background to attorneys new to the field and other health professionals who want a concise, effective overview of health care law. Other highlights include the Case Law Update and a special presentation entitled Health Care in the 1990s.

The remaining two days of the seminar will feature workshop sessions by leading experts on: alternative delivery systems; employee benefits; peer review; home health; medical staff; tax issues; medical technology; antitrust; Medicare reimbursement; joint ventures; ambulatory care; capital finance; house counsel; medical ethics; health planning and a variety of other issues.

For further information, please contact:

Jaime Doherty
Communications Director
National Health Lawyers Association
522 21st St., NW
Suite 120
Washington, DC 20006
(202) 833-1100

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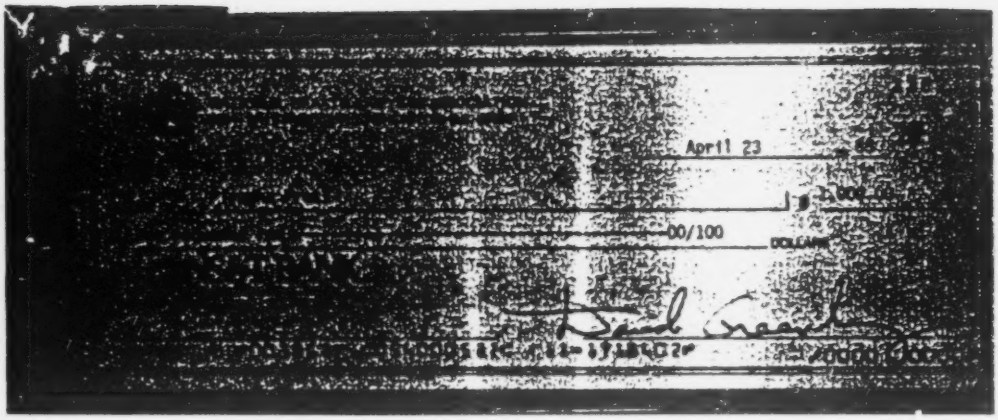
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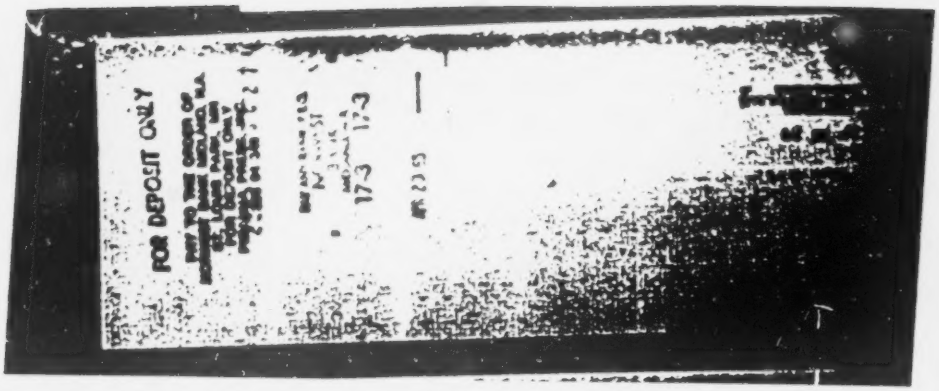
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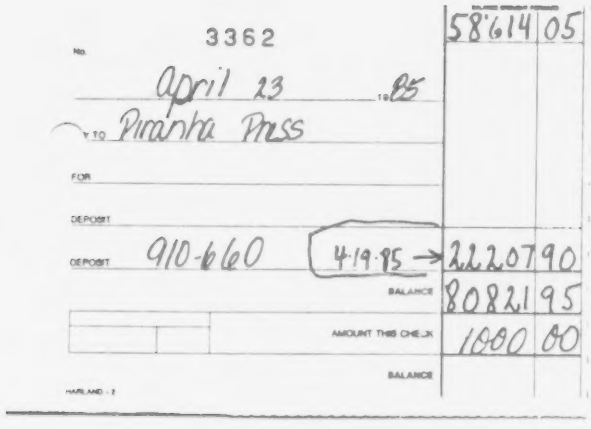

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HARLAND - 2

Tucson w/ Grassley

Sat morning breakfast:

8-9:30 am [only time DD must be there]

- wanted 2 Finance Committee Members

(Homebuilders Conference)
↓
group will pay all expenses for DD & PD all weekend.

- DD told me friday he wanted us to find him a speech or something so Grassley wouldn't have to pay. According to Grassley's office, the Homebuilders Conf. will pay.

e: John Barnes 40489

They don't have many details (Grassley people). They are waiting to know DD's schedule - Ha!

SPECIAL COUNSEL HEARING EX. 172 A

AMERICAN SOUTHWEST FINANCIAL NO. 6

NAME CORPORATION

ACCOUNT NO 3182-2015 FEBRUARY 27 86 91-2/1221

PAY TO THE ORDER OF DAVE DURENBERGER $ 2,000.00

THE SUM 2000 DOLS 00 CTS DOLLARS

VALLEY NATIONAL BANK 35TH AVE – BELL RD. OFFICE (535) P.O. Box 29531 Phoenix, Arizona 85038

ASW0006

MEMO honorarium

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AMERICAN SOUTHWEST FINANCIAL

NAME CORPORATION NUMBER

ACCOUNT NO. 3182-2015

FEBRUARY 27, 86 91-2/1221

PAY TO THE ORDER OF DAVE DURENBERGER $ 2,000.00

THE SUM 2000 DOLS 00 CTS DOLLARS

VALLEY NATIONAL BANK 19TH AVE. – BELL RD. OFFICE (170) P.O. Box 29511 Phoenix, Arizona 85038

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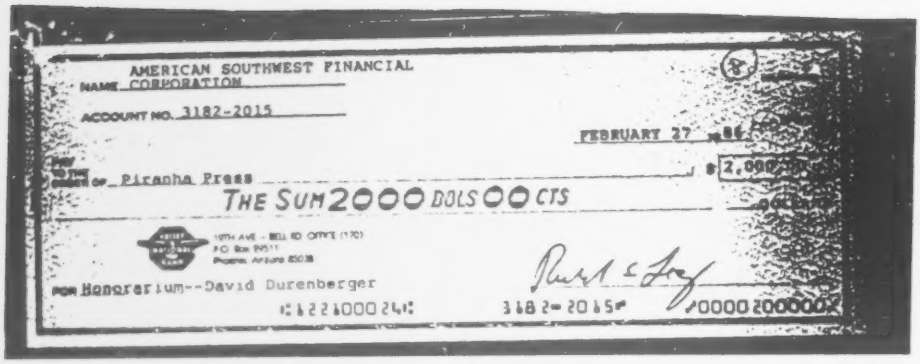

AMERICAN SOUTHWEST FINANCIAL
NAME CORPORATION
ACCOUNT NO. 3182-2015
FEBRUARY 27 19 86
PAY TO THE ORDER OF Piranha Press
$ 2,000.00
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PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
320 04 348

D

*time for attendance at finance hearing is tentative; the scheduling meeting will also be before 10:45am

FRIDAY, FEBRUARY 28, 1986

8:00am Minnesota Goodroads Breakfast at the Channel Inn, 650 Water St. phone: 554-2400 s: DMc

*9:30am Finance Committee Hearing - SD-215 re: oil import fees

10:45am Meeting with Jim Harrison, Ex Dir, and Frederick Funk, Chairman, MN-WI Boundary Area commission in the office for 15 minutes re: Upper Mississippi legislation

11:00am PHOTO with Rita Nething, Republican Page

Stop-by/PHOTO with Diane Ahrens, Chair of the Ramsey County Board of Commissioners re: concerns of the expected influx of refugees to MN and impact of Gramm-Rudman on local governments

11:15am Stop-by/PHOTO with reps of the MN Firefighters re: tax reform (meeting to begin at 11:00am)

11:30am Meeting with Ambassador Carlos Tunnerman of Nicaragua in the office s: BMc c: Wm Vigil - 387-4371

12:00pm Lunch meeting with AP, MW, and CK re: bonds proposal

2:00pm Interview with Linda Stern of the New York Journal of Commerce re: tax reform and AGE

2:57pm Depart Washington for Dallas on American Airlines flight #567
(Priority wait-listed for 1st class-check at the gate.)

5:49pm Arrive Dallas

6:43pm Depart Dallas for Tucson on American Airlines flight #619

7:59pm Arrive Tucson - Greg Andrews (Bracy, Williams, & Co.) and limo to meet Senator at the gate (he will be holding a Durenberger sign)

8:30pm Arrive Loews Ventena Canyon Resort - 602-299-2020
DD to be met by representative from Homebuilders Assn. He will take DD's luggage to room.

8:45pm Remarks to Housing American Foundation/Estes Company (Piranha speech)
re: tax reform (AP briefing material)
85-90 people 30-40 minutes plus 10 mins Q&A

Overnight Loews Ventena Canyon Resort
DD has suite

E

National Association of Home Builders

National Housing Center
15th and M Streets, N.W., Washington, D.C. 20005
Telex 89-2600 (202) 822-0470

Robert D Bannister
Senior Staff Vice President

MEMORANDUM

TO: Dave Smith

FROM: Bob Bannister

SUBJECT: Meeting of Committee to Preserve Homeowner bonds

DATE: March 14, 1986

By all accounts, the recent meeting in Tucson, Arizona seems to have been a success. There were 42 participants at the meeting, many of whom approached me aftewards with favorable comments. For example, Dave Glickman (a former Deputy Assistant Treasury Secretary) told me how much he was impressed with the professionalism of both the presentations and the materials.

As you know, the group was addressed by several Members of Congress and Senators: Senator Durenberger (R-Minn.), Senator De Concini (D-Ariz.), Senator Grassley (R-Iowa), Senator Specter (R-Pa.), Rep. Gibbons (D-Fla), Rep. McCain (R-Ariz.), and Rep Udall (R-Ariz.). After we got back to Washington, Senator Specter asked me to draft a letter for him to send to Senator Packwood, urging preservation of homeowner bonds.

It looks like we have won the first round with the Senate on this issue, since the Senate Finance Committee staff markup document preserves present law treatment of homeowner bonds.

F

PN Advise 9/10
(T.) yes check with Mahony

NATIONAL MULTI HOUSING COUNCIL
Suite 620 • 1250 Connecticut Avenue, N.W. • Washington, D.C. 20036 • 202/659-3381

August 19, 1985

The Honorable Dave Durenberger
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

The National Multi Housing Council will be holding its quarterly Board Meeting on Tuesday, September 10 at the Sheraton Grand Hotel on Capitol Hill. We would very much like you to be our keynote luncheon speaker on that day. You may recall, a snowstorm in Minnesota this past March delayed your flight precluding you from speaking to this same group.

Your audience will be approximately 30 individuals who are principals in the real estate industry, primarily in the areas of development and syndication. There will be a reception from 12:00 - 12:30 with lunch scheduled from 12:30 - 2:00. I anticipate your remarks to be 15 minutes followed by 15 minutes of questions and answers. The topic will be tax reform and your insight on the real estate issues and prognosis for passage. We would like to offer a $1,000 honorarium if it is your policy to accept honorariums.

I know our directors would benefit greatly from your opinions on tax reform and hope you are able to accept our invitation.

Sincerely,

Debbie Shannon
Director, Legislative Liaison

SPECIAL
COUNSEL
HEARING
EX. 173

A

8/19

Kelly.

If you could get me word of any decision ASAP it would be very helpful in putting together our agenda as in finding another speaker if he's not able to do it. Thanks much!

Debbie

National Multi Housing Council

B

2. TO: TAMARA 1/3 PN Astrix 9/10
FR: KELLI
8/29

H

NATIONAL MULTI HOUSING COUNCIL
Suite 620 • 1250 Connecticut Avenue, N.W. • Washington, D.C. 20036 • 202 659 3381

TO Mahoney Jon

August [illegible], 1985

The Honorable Dave Durenberger
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

The National Multi Housing Council will be holding its quarterly Board Meeting on Tuesday, September 10 at the Sheraton Grand Hotel on Capitol Hill. We would very much like you to be our keynote luncheon speaker on that day. You may recall, a snowstorm in Minnesota this past March delayed your flight precluding you from speaking to this same group.

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I know our directors would benefit greatly from your opinions on tax reform and hope you are able to accept our invitation.

Sincerely,

Debbie Shannon

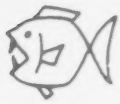
Debbie Shannon (WILL PICK UP)
Director, Legislative Liaison

Busy day 0930
FC sub Red tax 1000
Hrg re eq tax
Got Aft Civ Sec ?
Conflicts of Rep Mtng (lunch
(Hospital same day flex. Bill in
aft.)

12:00 - 12:30 COCKTAILS
12:30 - LUNCH
1:00 - 1:45 TALK + QA
(1:30 - 1:45 RUN OF THERE)
W: (659 - 3381)
H: 892 - 2824
SHERATON GRAND HOTEL

C

PIRANHA



PRESS

Gary L. Diamond
Publisher

September 9, 1985

Ms. Debbie Shannon
Director, Legislative Liaison
National Multi Housing Council
Suite 620
1250 Connecticut Avenue NW
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Ms. Shannon:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the National Multi Housing Council on September 10, 1985.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

D

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Anne Kelly
Ms. Kitty Gamble

E

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
September 10, 1985	12:00-2:00 p.m.	Washington, DC	$2,000

QUARTERLY MEETING OF THE
NATIONAL MULTI HOUSING COUNCIL
BOARD OF DIRECTORS AND ADVISORY COMMITTEE

September 10, 1985
Washington, D.C.

The quarterly meeting of the Board of Directors and Advisory Committee of the National Multi Housing Council, Inc., was held at the Sheraton Grand in Washington, D.C. on September 10, 1985.

Present were:

BOARD OF DIRECTORS

Dennis Alberts; The Trammell Crow Company;
Alternate Director for Tom Teague

Kelley Bergstrom; JMB Property Management Corporation

Preston Butcher; Lincoln Property Company

Allen Cymrot; Kemper/Cymrot, Inc.

Richard Fore; Lincoln Property Company

Dallas Gwynn; The Balcor Company

W. Patrick McDowell; The Fox Group

Seamus McKeever; Angeles Corporation;
Alternate Director for William Elliott

Robert Miller; The Robert A. McNeil Corporation
Alternate Director for Robert McNeil

John Nelson; Winthrop Financial Company, Inc.

Geoffrey Stack; Regis Homes Corporation

ADVISORY COMMITTEE:

Richard Corey; Wertheim & Company

Jonathan Katz; The Beal Companies

Jonathan Kempner; Oxford Development

G

Kent Levenson; EPIC Commercial Investment Corporation

Frank Livingston; Draper & Kramer

Tom Mahaffey; The Mahaffey Company

Ted Mitchell; The Grupe Company

Tom Moran; Moran & Company

William Moses; Community Housing Improvement Program/Rent Stabilization Association

Jeffrey Rosenthal; Real Estate Securities & Syndications Inst.

GUESTS

Frank West; Bill Hecht & Assoc. representing the Irvine Co.

Aaron Barman; Prudential-Bache

STAFF

Stephen Driesler; Executive Vice President

Susan Riley; Director Governmental Relations

Deborah Shannon; Director Legislative Liaison

Jean Hussey; Director Finance and Administration

Desire Anderson; Director Membership

David Freibert; Director Public Relations and Research

Iris Williams; Administrative Assistant

Lawrence Simons; Powell, Goldstein, Frazer & Murphy; Legislative Counsel

Carolyn Seeley; Powell, Goldstein, Frazer & Murphy; Legislative Counsel

GUEST SPEAKERS

Congressman Beryl Antlhony (D-Arkansas) Member, House Ways & Means Committee

Congressman Robert Matsui (D-California) Member, House Ways & Means Committee

Senator Dave Durenberger (R-Minnesota) Member, Senate Finance Committee

H

I. APPROVAL OF MINUTES, JUNE 3, 1985, MEETING OF DIRECTORS AND ADVISORS

On a motion by Mr. Bergstrom and seconded by Mr. Nelson, the minutes of the June 3, 1985 meeting of Directors and Advisors were approved by the Board.

II. APPROVAL OF NEW DIRECTORS

On a motion by Mr. Hediger, seconded by Mr. Cymrot and approved by the Board the following were appointed as Directrors of the National Multi Housing Council

Mr. Abe Gelber; Integrated Resources
Mr. Dean Spanos; A.G. Spanos Construction

On a motion by Mr. Bergstrom seconded by Mr. McDowell, and approved by the Board Mr. Robert Utley , Chairman and President of First Southwest Equity was named to replace Douglas Paisley as Director.

III. NEW BUSINESS

Mr. Cymrot announced that he and Mr. Butcher would like to put together a compensation committee to come up with a compensation package for Steve Driesler and perhaps some other staff for 1986.

On a motion by Mr. Hediger and seconded by Mr. McDowell the Board approved the formation of a compensation committee.

IV. 1985 FINANCIAL AND MEMBERSHIP UPDATE

A. Membership Summary

Mr. Butcher reviewed the income from membership dues for 1985 and asked Directors/Advisors to assist in collecting outstanding dues. The following agreed to contact individuals regarding their dues.

- o Pat McDowell to contact Gene Branscome
- o Preston Butcher, Jeff Stack, Bob Sheridan to contact Sam Zell
- o Preston Butcher to contact Tom Freytag and Bob Folsom (Folsom to increase his $5,000 commitment)
- o Allen Cymrot to contact Howard Slayen

Memberships to be dropped are:

Jim Stout; J.D. Stout
Bob Avrett; WD&I Management
James Dahlgren; Macke Laundry

Membership income to date including new members totals $485,223. Dues outstanding from invoicing total $186,028 and total amount invoiced to date is $600,535.

B. Membership Recruitment New Member Breakdown

Mr. Butcher reviewed new memberships and those responsible for the new members. The following is a list of Directors/Advisors who have assisted in fundraising this year and how much each has raised.

Preston Butcher	$ 5,000
Allen Cymrot	5,000
Abe Gelber (1/3 of Irvine)	8,333
Gary Hediger (1/2 of Jacques-Miller)	1,250
Bob Miller (1/3 of Irvine)	8,333
Tom Teague	2,500
Rod Berle (1/3 of Irvine)	8,333
Bob Carpenter	3,000
Kent Levenson (1/2 of Jacques-Miller)	1,250

Earlier in the year Directors/Advisors were asked to sign commitment cards to bring in new memberships. Mr. Butcher asked the NMHC staff to notify those people of their commitments and ask them to follow up on their commitments.

V. NEW YORK FUNDRAISER

The National Multi Housing Council will host a major membership fundraiser in New York City in December. Mr. Butcher asked those present to put together a list of Wall Street brokerage firms their companies do business with as possible invitees for the fundraiser. Mr. Butcher also asked the NMHC staff to draft a letter Directors can use to invite bond placement agencies and brokerage firms to the fundraiser.

J

VI. POLITICAL ACTION COMMITTEE

Mr. Driesler reviewed the Council's Political Action Committee activity and reminded Directors/Advisors while PAC contributions are voluntary only 7 of 20 Directors are contributing to the PAC and 1 from the Advisory Committee. Mr. Driesler explained although the Council has been active in supporting members of the House Ways and Means Committee and Senate Finance Committee, there are many other members of Congress the Council should support but cannot because of lack of funds.

VII. PUBLIC RELATIONS

Mr. Driesler reviewed recent public relations efforts the Council has undertaken. NMHC contributed $5,000 toward the publication of a study prepared by the Joint Center for Housing Studies of MIT and Harvard University. The study, jointly funded by a number of housing-related associations, assesses the likely impacts of the President's Tax Proposals on rental housing.

In addition the Council has agreed to share the cost of a $60,000 media campaign on tax reform directed toward owners, renters and the general public. The advertisements, put together by the National Association of Home Builders and the National Association of Realtors, will cost the Council $10,000.

Mr. Fore was strongly in favor of a media blitz condemning tax reform proposals and rallying against efforts by President Reagan to sell his tax reform parkage.

VIII. RENT CONTROL UPDATE

Mr. Hediger discussed legal fees incurred for passage of the rent control preemption bill in South Carolina. The National Multi Housing Council has already contributed $4,500 and will pay an additional 1,957 to equal one-fourth of the total bill of $25,828. Mr. Hediger has commitments totaling $3,000 leaving a balance of $16,371 to be divided among Board and Advisory members who own property in South Carolina.

K

Mr. Butcher asked the NMHC staff to poll Directors and Advisors regarding states they would like NMHC to pursue for rent control preemption.

XI. LEGISLATIVE UPDATE

Mr. Butcher asked Directors/Advisors to show by hand vote which provisions of the tax reform proposals most affect their businesses. The top issues are:

- o Investment Interest Limitation
- o Depreciation and Recapture
- o Industrial Development Bonds
- o At-Risk Exemption

A discussion ensued regarding whether or not the National Multi Housing Council should attempt to carve out special tax treatment for rental housing or work to pressure favorable tax treatment for real estate generally. The feelings of the Board/Advisory Committee were mixed but it was generally agreed that NMHC should do whatever it could for real estate accross the board but when and if push comes to shove the organization's first priority has to be to do what is best for the rental housing industry.

Mr. Gwynn expressed concern that NMHC should continue to work with other commercial real estate groups as closely as possible.

X. ADJOURNMENT

The quarterly meeting of the National Multi Housing Council Board of Directors and Advisory Committee was adjourned at 12:00 pm.

Respectfully Submitted,

Stephen D. Driesler
Executive Vice President

NMHC National Multi Housing Council · Suite 630, 1850 Connecticut Avenue, N W · Washington, D C 20036 · (202) 659-3381

Washington Watch

LEGISLATIVE & REGULATORY ACTIVITY

September 12, 1985

At the September Board of Directors/Advisory Committee meeting held in Washington, D.C. this week, three members of the House Ways and Means Committee told NMHC Board/Advisory Committee Members that they expected to send a tax reform plan to the Senate sometime around Thanksgiving. Congressmen Frank Guarini (D-NJ), Beryl Anthony (D-Ark), and Robert Matsui (D-CA) all agreed that while President Reagan and House Ways and Means Chairman Rostenkowski appear to be the only two people in Washington who strongly desire tax reform at this time, their combined influence will be enough to push a bill through the House before the Thanksgiving congressional recess.

Serious doubts remain, however, about whether the Senate will move on tax reform this year. In fact, Senator David Durenberger (R-MN), also addressing the NMHC Board and Advisory Committee, doubted seriously the Ways and Means Committee's ability to draft revenue neutral tax reform legislation this year which would have the support of a majority of the members of the House of Representatives and keep the full support of the White House.

Durenberger noted that he and his colleagues on the Senate Finance Committee were assuming a wait and see posture while the House begins action on tax reform. Durenberger stated that he and follow Senators feel the deficit and trade issues demand more immediate attention and the Senate would focus on them while the House wrestled with the nation's tax structure.

Representatives Guarini, Matsui and Anthony also expressed concern that more pressing problems such as trade and the deficit were being put aside for tax reform. Each said, however, that most Congressmen would not want to campaign for re-election labled as an opponent of an effort to make the tax system more equitable and simple, and therefore would likely vote for the bill. A similar analysis applied equally to those Senators up for re-election in 1986.

Both Matsui and Anthony referred to Treasury Secretary Baker's visit to the Ways and Means Committee's retreat and the indication that the President is willing to compromise on some controversial issues like the deductibility of state and local taxes as increasing chances a bill would be passed. They noted, however that the President's insistence on a top individual bracket of 35% plus revenue neutrality made the process much more difficult.

- more -

M

Representative Anthony urged those present, and all leaders in the real estate industry, to participate in the legislative process by submitting possible compromises and alternatives to members of the Ways and Means Committee before the markup of the bill begins later this month.

Representative Matsui suggested that NMHC members should make their concerns over the tax bill known to their Congressmen as well as Ways and Means Committee members as soon as possible if they hope to have influence on the outcome of this legislation.

N

NATIONAL MULTI HOUSING COUNCIL
1250 CONNECTICUT AVENUE, N.W., SUITE 620
WASHINGTON, D.C. 20036
PHONE 202 659 3381

INVOICE	AMOUNT
Honorarium	

No 6624

15-3
540

The RIGGS NATIONAL BANK
of WASHINGTON, D.C.
18TH AND M OFFICE
1800 M STREET, N.W.

PAY One thousand and 00/100 — DOLLARS

DATE	TO THE ORDER OF	CHECK NO	RE AMOUNT OF CHECK	
9/23/85	Prairie Press	6624	2000	00

Sen. Durenberger Honorarium

TWO SIGNATURES REQUIRED FOR CHECKS OVER $1,000.00

4504 Excelsior Blvd.
Minneapolis, MN 55416

John F. Hussey
[illegible]

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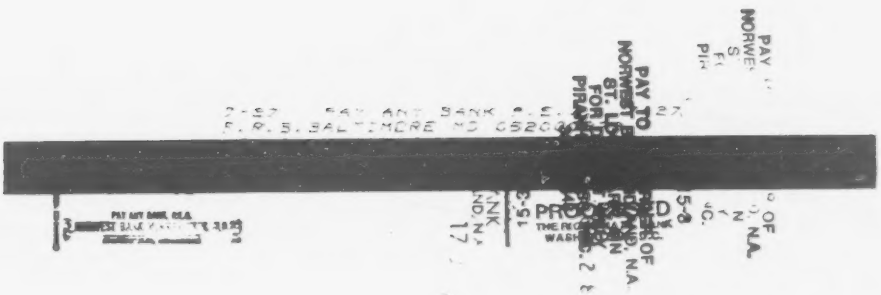

NATIONAL MULTI HOUSING COUNCIL

Stephen D Driesler • Executive Vice President
Suite 620 • 1250 Connecticut Avenue N W • Washington, D C 20036 • (202) 659 3381

September 23, 1985

The Honorable Dave Durenberger
United States Senate
375 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Board of Directors, Advisory Committee and the staff of the National Multi Housing Council, thank you for your appearance at our Board of Directors meeting on September 10 at the Sheraton Grand Hotel. Our members and staff all found your remarks and candid answers very enlightening and useful as the tax reform process gets underway in Congress.

Again, the National Multi Housing Council thanks you for your participation as a guest speaker and we were pleased to foreward an honorarium in the amount of $2,000 to Piranha Press.

If we can ever be of any assistance to you, please do not hesitate to let us know.

Sincerely,

Stephen D. Driesler
Executive Vice President

Q

NATIONAL MULTI HOUSING COUNCIL

Stephen D Driesler • Executive Vice President
Suite 620 • 1250 Connecticut Avenue N W • Washington D C 20036 • (202) 659 3381

September 23, 1985

The Honorable Beryl E. Anthony, Jr.
United States House of Representatives
1117 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Congressman Anthony:

On behalf of the Board of Directors, Advisory Committee and the staff of the National Multi Housing Council, thank you for your appearance at our Board of Directors meeting on September 10 at the Sheraton Grand Hotel. Our members and staff all found your remarks and candid answers very enlightening and useful as the tax reform process gets underway in Congress.

Again, the National Multi Housing Council thanks you for your participation as a guest speaker.

If we can ever be of any assistance to you, please do not hesitate to let us know.

Sincerely,

Stephen D. Driesler
Executive Vice President

R

NATIONAL MULTI HOUSING COUNCIL
1250 CONNECTICUT AVENUE N.W., SUITE 620
WASHINGTON, D.C. 20036
PHONE 202 659-3381

INVOICE	AMOUNT
Contribution	

№ 6590 15-3/540

The RIGGS NATIONAL BANK of WASHINGTON, D.C.
19TH AND M OFFICE
1900 M STREET N.W.

PAY [illegible] DOLLARS

DATE	TO THE ORDER OF	CHECK NO	NET AMOUNT OF CHECK				
9/7/83	[illegible]	6590	1000	00			Contribution

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NATIONAL MULTI HOUSING COUNCIL

Stephen D. Driesler • Executive Vice President
Suite 620 • 1250 Connecticut Avenue, N.W. • Washington, D.C. 20036 • (202) 659-3381

September 23, 1985

The Honorable Robert T. Matsui
United States House of Representatives
231 Cannon House Office Bldg.
Washington, D.C. 20515

Dear Congressman Matsui:

On behalf of the Board of Directors, Advisory Committee and the staff of the National Multi Housing Council, thank you for your appearance at our Board of Directors meeting on September 10 at the Sheraton Grand Hotel. Our members and staff all found your remarks and candid answers very enlightening and useful as the tax reform process gets underway in Congress.

Again, the National Multi Housing Council thanks you for your participation as a guest speaker and we were pleased to enclose an honorarium in the amount of $1,000.

If we can ever be of any assistance to you, please do not hesitate to let us know.

Sincerely,

Stephen D. Driesler
Executive Vice President

NATIONAL MULTI HOUSING COUNCIL
1250 CONNECTICUT AVENUE, N.W., SUITE 620
WASHINGTON, D.C. 20036
PHONE 202 659 3381

INVOICE	AMOUNT

№ 6625

15-3
540

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of WASHINGTON D.C.
18TH AND M OFFICE
1800 M STREET, N.W.

PAY One thousand and 00/100 — DOLLARS

DATE	TO THE ORDER OF	CHECK NO	NET AMOUNT OF CHECK	
9/23/85	The Hon Robert Matsui	6625	1000 00	Honorarium

TWO SIGNATURES REQUIRED FOR CHECKS OVER $1,000.00

T

Reilly - AA

PRE-APPOINTMENT INFORMATION

EVENT DATE: 10/1 (Ballroom level lowest level Collette 9/20 Coleman 9/20 intvs: Chm & Pres. Ted Balistreri (from Cal)) TODAY'S DATE: (9/20)

CONTACT: Bob Bird

TELEPHONE: General Mills 463-6590

APPOINTMENT WITH: (DD) STAFF Speech 20-25 min 15 @ AA

FOR: Governmental Relations people

TITLE: Nat'L Restaurant Assoc.

COMPANY: @ JW Marriott introduced @ 8:05 but before 9:00

ISSUE: 8:00 am B-fast @ 7:30 tax bill outlook - prospects for reform → Insurance, estate, retirement, meal & expenses

NUMBER OF PEOPLE:

ADDITIONAL NAMES: 200 + people Public affairs conference 1st speaker $2000 Honorarium for 1st conference

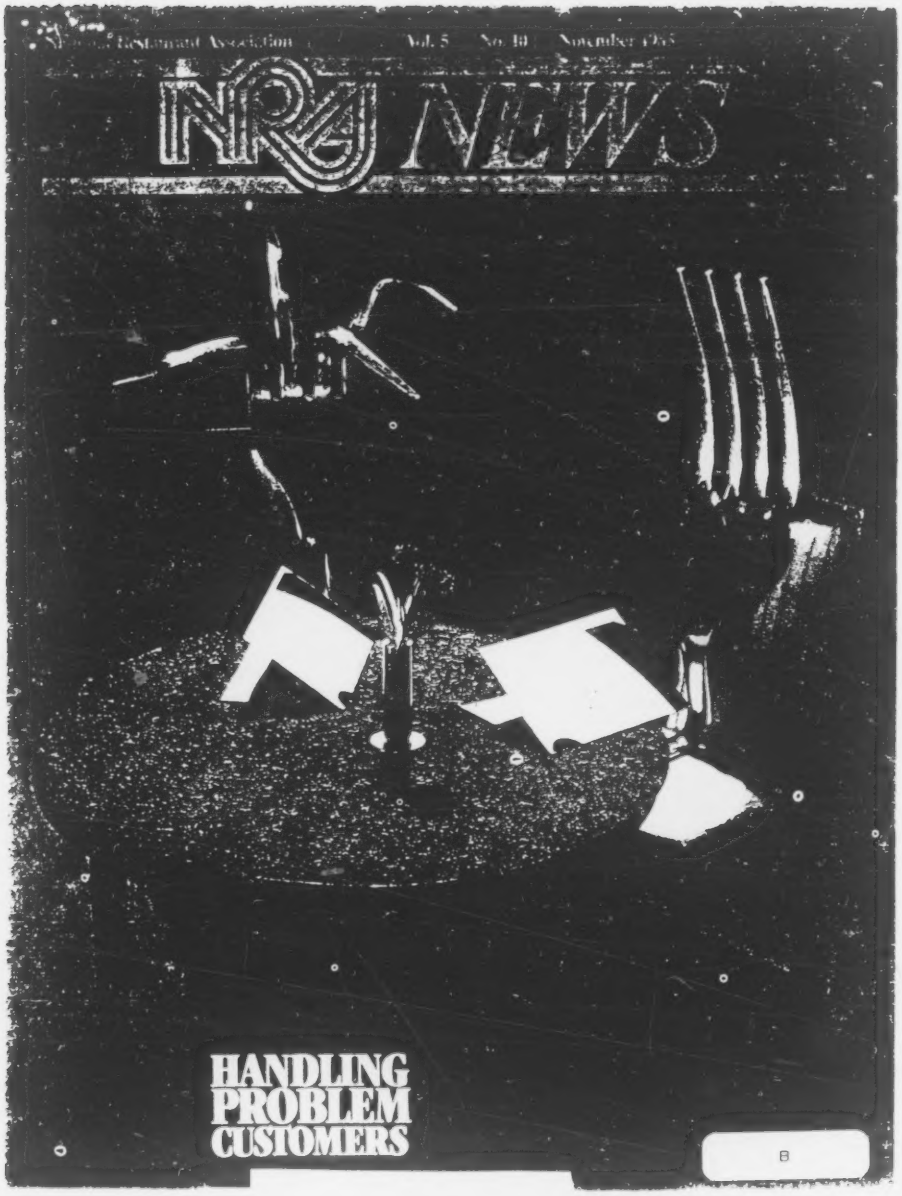
Conflict w MN Delegation B-fast

NOTES: arrive [redacted] OK per 9/20/85 DD mtg Rest assoc. Jack Kozlack → from MN

Jan Rogers — Past Pres of Rest Assoc
Nat'l Rest Assoc — Pres of Gen Mills Rest Group → Dale Lee serves on bd of Gen Mills
638-6100

SPECIAL COUNSEL HEARING EX. 174

A


Restaurant Association
Vol. 5 No. 10 November 1965
NRA NEWS
HANDLING
PROBLEM
CUSTOMERS
B

Recipe for action

NRA hosts first Public Affairs Conference

Congress felt the foodservice industry flex its muscles last month when NRA held its first-ever Washington Public Affairs Conference. More than 200 restaurateurs converged on Capitol Hill to lobby for the industry.

The two-day conference (October 1, 2) combined sessions with influential national leaders, such as Senate Majority Leader Bob Dole (R-KS), with personal visits with members of the House and Senate to discuss foodservice issues.

Agriculture Secretary John Block, House Republican Whip Trent Lott (R-MS), Senate Majority Leader Bob Dole (R-KS) and House Budget Committee Chairman Bill Gray (D-PA) were just a few of the speakers NRA lined up for the first conference of this kind.

Senate Majority Leader Bob Dole (R-KS) outlined the major issues affecting the Senate this fall, placing particular emphasis on deficit reduction, farm legislation and tax reform. Dole said that in his eyes reducing the deficit is much more important than reforming the tax code. He said that more cuts can be made in federal spending and that he agreed with the President that raising taxes should be a last resort.

Sen. David Durenberger (R-MN), left, with one of his constituents, NRA Director Jack Koziak, right. Durenberger spoke to the conference about tax reform, emphasizing that Congress must consider reform's impact on investment, personal savings and consumption.

PUBLIC AFFAIRS CONFERENCE

NATIONAL RESTAURANT ASSOCIATION

SEPTEMBER 30/OCTOBER 1&2, 1985

PIRANHA

PRESS

Gary L. Diamond
Publisher

January 17, 1986

Mr. Jim Rogers
311 First Street NW
Washington, DC 20001

RE: SPEAKING ENGAGEMENT BY SENATOR DAVE DURENBERGER

Dear Mr. Rogers:

In connection with Senator Durenberger's appearance before the National Restaurant Association on or about October 1, 1985, you were to make payment in the amount $2,000 to the undersigned. Our records indicate that this amount has not been paid. We would appreciate payment as soon as possible.

If payment has been made, please disregard this letter.

Very truly yours,

GARY L. DIAMOND

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

E

V # 302393

RECEIVED
JAN 31 1986

HONORARIUM REQUEST

All requests will be dealt with on a case-by-case basis, considering campaign vs. personal need, philosophy of recipient, past NRA-PAC, NRA-PEC contributions, Board member contacts, and needs of specific event.

Member of Congress: Sen. Dave Durenberger Date: Jan 31, 1986

Social Security #: 471-364-210 Amount: $2,000

****

Check Payable To: Senator Dave Durenberger
(If different than Member listed above)

Address : 375 Russell Building
Washington, D.C. 20510

****

Party Republican Incumbent: yes X no ____

Senate: X House: ____ State: MN District: ____

****

Event: Public Affairs Conference '85

Date: Oct. 1, 1985

Location: ____

Staff person responsible: ____

Check presented by: ____

Board of Directors contact: ____

Remarks: ____

Submitted by: Jim Rogers
Government Affairs Staff

Reviewed by: _____ _____
Manager, Political Affairs Senior Director, Govt. Affair

FOR ACCOUNTING OFFICE:
Please charge Political Education Committee Account #50-56-08-6960

F

NATIONAL RESTAURANT ASSOCIATION
311 FIRST ST., N.W.
WASHINGTON, D.C. 20001

GENERAL ACCOUNT

PAY

DATE	CHECK NO.
2-4-86	10255

15-4
540

THE SUM 2000 DOLS 00 CTS

PAY EXACTLY
$***2000.00***

TO THE
ORDER OF ***Sen. Dave Durenberger***

Ruth K Tracy
Authorized Signatur

Peter D Ord
Authorized Signatur

FIRST AMERICAN BANK, NA
WASHINGTON, D.C.

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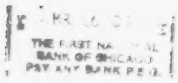

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NATIONAL RESTAURANT ASSOCIATION — 311 FIRST ST., N.W. — WASHINGTON, D.C. 20001

VENDOR NUMBER	VENDOR NAME	CHECK DATE	CHECK NO
302893	Sen. Dave Durenberger	2-4-86	1025

MEMO INFORMATION	INVOICE IDENTIFICATION	INVOICE DATE	INVOICE AMOUNT	TERMS DISCOUNT	AMOUNT PAID
Honorarium: Public Affairs Conference Oct. 1, 1985		1-31-86	2000.00	Total	2000.00
A#50-56-08-6960-02	bdt				

NATIONAL RESTAURANT ASSOCIATION
311 FIRST ST., N.W.
WASHINGTON, D.C. 20001

GENER/
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PAY

DATE	CHEC
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THE SUM 2000 DOLS 00 CTS

PAY EXACTLY
$***2000.00***

TO THE
ORDER OF ***Sen. Dave Durenberger***

Ruth K Trac
Authorized S

Peter D. Bird
Authorized S

FIRST AMERICAN BANK, NA
WASHINGTON, D.C.

⑈102557⑈ ⑆054000043⑆ 3 213 617⑈

I

POLITICAL EDUCATION COMMITTEE
NATIONAL RESTAURANT ASSOCIATION
311 FIRST STREET, N.W.
WASHINGTON, DC 20001

(202) 638-
(800) 424-

Richard E. Marriott, Chairman
Marriott Corporation
Washington, D.C.

Jim L. Peterson, Vice Chairman
Whataburger, Inc.
Corpus Christi, Texas

W. W. "Buff" Naylor, Secretary
Naylor Brothers Restaurants, Inc.
Los Angeles, California

Ralph R. Evans
Evans Farm Inn
McLean, Virginia

Kenneth Hill
T.J. Cinnamons, Ltd.
Kansas City, Missouri

Jack A. Laughery
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General Mills Restaurant Group, Inc.
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Gaston Corporation
Greene, Iowa

Terry Vince
Stan, Inc.
Wakefield, Massachusetts

Ted J. Balestreri
Sardine Factory, Inc.
Monterey, California

Corporate contributions to N.R.A.'s Political Education efforts are greatly appreciated and can be applied to the Political Education Fund activities to promote industry improvement in government.

February 5, 1986

Honorable Dave Durenberger
United States Senate
375 Russell Building
Washington, DC 20510

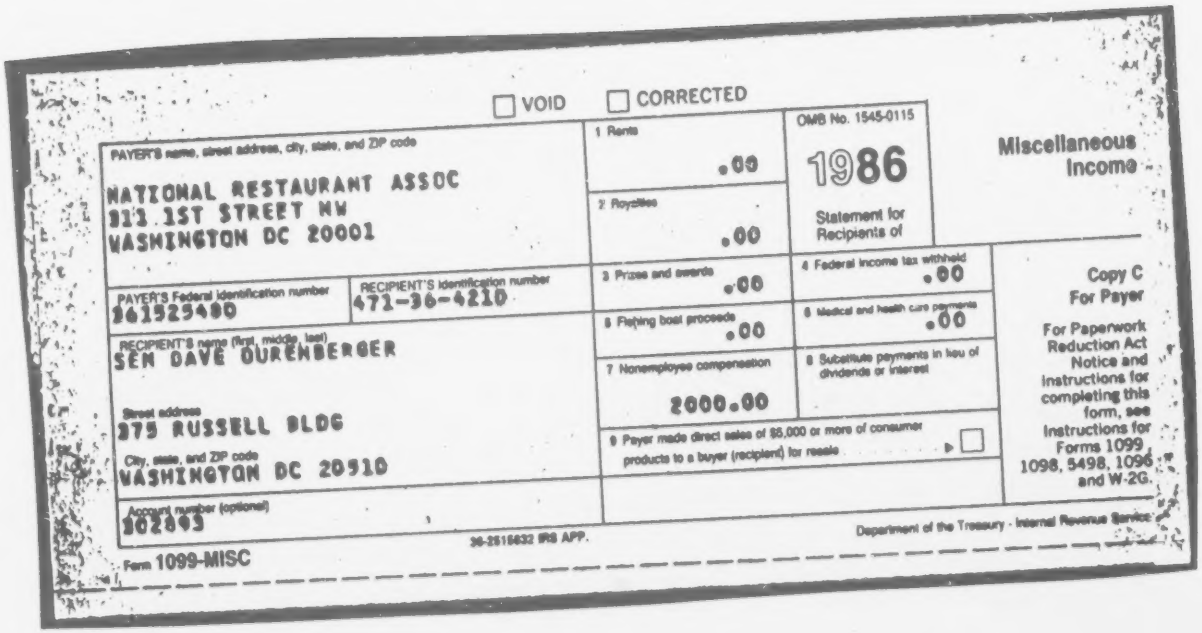
Dear Senator Durenberger:

On behalf of the members of the National Restaurant Association Political Education Committee, I sincerely thank you for taking time to meet with us at our Public Affairs Conference. We very much enjoyed your remarks and hope that we offered some insight as to what our industry represents.

Again, we were so pleased that you were able to join us. Please let us know if the National Restaurant Association can assist you in any way.

Sincerely,

Richard E. Marriott
Chairman, Political Education Committee



☐ VOID ☐ CORRECTED

PAYER'S name, street address, city, state, and ZIP code

NATIONAL RESTAURANT ASSOC
311 1ST STREET NW
WASHINGTON DC 20001

1 Rents .00

2 Royalties .00

OMB No. 1545-0115

1986

Statement for Recipients of

Miscellaneous Income

PAYER'S Federal identification number 261525400

RECIPIENT'S identification number 471-36-4210

3 Prizes and awards .00

4 Federal income tax withheld .00

RECIPIENT'S name (first, middle, last) SEN DAVE DURENBERGER

5 Fishing boat proceeds .00

6 Medical and health care payments .00

Street address 379 RUSSELL BLDG

City, state, and ZIP code WASHINGTON DC 20510

7 Nonemployee compensation 2000.00

8 Substitute payments in lieu of dividends or interest

9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐

Account number (optional) 302863

Copy C For Payer

For Paperwork Reduction Act Notice and Instructions for completing this form, see Instructions for Forms 1099, 1098, 5498, 1096, and W-2G.

Form 1099-MISC

36-2516632 IRS APP.

Department of the Treasury - Internal Revenue Service

SCHEDULING INFORMATION

gen confirmed 10/1/86

SPECIAL COUNSEL HEARING EX. 175

A

SPEECH — 11/18/86 1.45am
TYPE OF EVENT — EVENT DATE/TIME

Natl Rural Electric Cooperative Assoc
GROUP NAME

Contact Rob Livelli
Phone 857-9633
Key People
Topic

SPEECHES
Group Size ~~450~~ ~60
~~Honorarium~~ $2K
Piranna (amount)
Room Set-Up
Introduction by Rob Cabat
Taped (y/n) Transcript Dr. Management Services

FOLLOW-UP — Rob Cromartie to meet DD
Thanks Sent (date)
Photo (y/n) Sent (date)
Photo to Media (date)

LOCATION OF EVENT Washington DC
Place ~~Washington Hilton~~ Washington Hilton
Room
Phone Number
Directions

Membership Lists
Received (y/n)
Computerized (y/n)
Filed (y/n)
Regret Sent
Greeting Sent (y/n)

STAFFING
Briefing Memo
Photo
Speech

MISCELLANEOUS
Mozart [illegible]
Irish → [illegible]
in cat package Everyone will have copy of IGR report → 20-30 min remarks
Grassley pulled in my Q+A to follow → extend 401k
DD helpful tax/rural electrics [illegible]

5/19/86
REQUEST DATE

NRECA NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
1800 Massachusetts Avenue, N.W., Washington, D.C. 20036
Telephone: (202) 857-9500

May 19, 1986

Honorable David Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

I am writing to invite you to speak before the 1986 NRECA Managers' Orientation Program on Tuesday, November 18, 1986 from 11:45 AM to 1:30PM here in Washington at the Park Terrace Hotel. There will be approximately 40 managers and 20 spouses from systems around the country who will be participating in this program in order to acquaint themselves with our national organization. In consideration for your remarks before this group, we are prepared to offer an honorarium of $2,000.

The role of the manager is to implement the policy decisions of the board and to effectively manage his or her staff to accomplish the goals of the cooperative. With this in mind, it is imperative that these managers, who are relatively new to their position, be exposed to legislators such as yourself, who are involved with issues of great concern to them like tax reform, environmental regulation, federal budget deficits, and the cost of health care. At the luncheon address, we would suggest that 30 to 45 minutes of prepared remarks would be appropriate with an equal amount of time following for questions and answers.

As additional background on our program, its problems, and its issues, I have enclosed for your review the most current editions of the Rural Electric Magazine and the Rural Electric Newsletter. An opinion survey of our managers, directors, and consumer-members has also been enclosed.

I would be most appreciative if you would let me know at your earliest convenience whether you will be able to accept our invitation. My telephone number is 857-9633.

Sincerely,

Rob Lively
Legislative Representative

Enclosures → Bob Bergland - Ex VP - Gen Mgr.

RL:sm

99th Congress
2d Session

COMMITTEE PRINT

S. PRT
99-176

GOVERNING THE HEARTLAND: CAN RURAL GOVERNMENTS SURVIVE THE FARM CRISIS?

REPORT

OF THE

SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

JULY 1986

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE
62-720 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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EXECUTIVE SUMMARY

For three years the nation's newspapers have been filled with headlines describing the growing farm crisis. The public has learned of serious financial problems facing America's farmers, and of the massive drops in real farm income and farm land values which have occurred during this decade. Attention has been focused on the direct, often dramatic impacts on individual farmers, their families, and on small businesses in America's agriculturally dependent communities.

Another dimension of the farm crisis has been largely overlooked--the growing threat to the financial viability of rural local governments. Declining farm incomes and farm property values erode the local tax base. At the same time, demands for many publicly provided services increase, creating a squeeze between falling revenues and higher costs. In many communities this financial vise is being tightened further by cuts in federal and state aid.

If these trends continue local officials cannot avoid both cutting services and increasing taxes. In the absence of such actions, local government revenues will fall short of existing expenditure levels by $106 per capita on average in the eight agriculturally dependent multi-county regions examined. Under more pessimistic assumptions about further drops in land values and cuts in intergovernmental aids, per capita revenue shortfalls of $250 or more were estimated for some areas. The higher taxes

and reductions in services necessary to overcome those shortfalls have the potential to permanently change the quality of life in much of rural America.

THE TROUBLED AGRICULTURAL ECONOMY: Since 1980, net farm incomes have fallen precipitously. From 1980 through 1984, real farm incomes averaged only $25 billion in 1982 dollars, down nearly 40 percent from the average of the seventies and down more than 25 percent from the average of the sixties.

When farm incomes decline, main street spending also falls, eliminating jobs and reducing incomes in the local commercial sector. The size and scope of those impacts was estimated for a nine county region in southwestern Minnesota. Assuming that the average farm income levels of the early 1980's continue, there are 3650 fewer commercial sector jobs (about 15 percent) than there would have been, other things equal, had the high income years of the mid-1970's continued.

VANISHING WEALTH: The decline in agricultural income since 1981 has produced an enormous drop in the value of farmland. Nationwide, agricultural land values fell by more than 30 percent, or $227 per acre, during the past four years. Farm land values declined only one other time in the postwar period, in 1954, when they fell by one dollar.

When viewed in constant dollars, the results are even more sobering. Nationwide, between 1982 and 1985, farm land values fell by $146 billion--a loss of wealth for farm land owners equal

to the combined assets of IBM, GE, Kodak, Proctor & Gamble, 3M, Dow Chemical, McDonalds, RCA, Upjohn, Weyerhauser, and CBS.

IMPACTS ON LOCAL PROPERTY TAXES: Over time this massive devaluation in farm assets will significantly erode the local tax base in some communities. Those impacts are already evident in Minnesota where taxable valuations dropped about 25 percent between 1983 and 1985. In other states, agricultural assessed values have remained relatively stable when measured in current dollars because assessment systems based on the productivity of agricultural land are slower to adjust to changes in market values. Nevertheless, taxable valuations have already dropped an average of 20 percent since 1981 in inflation adjusted dollars. With land values continuing to fall, it is only a matter of time before declines in assessed valuations in current dollars are observed.

Dramatically increased rates of property tax delinquencies are a leading indicator of future problems. Between 1980 and 1985, annual delinquencies jumped sevenfold in the Nebraska localities examined--rising from $.75 million to over $5.5 million. Delinquencies also more than doubled in the Iowa, Kansas, Minnesota, and Montana communities surveyed.

THE SERVICE SQUEEZE: Rural governments are being squeezed by increased service demands as well as falling revenues. Many of the new demands for services are a direct response to increasing unemployment in the agriculturally dependent regions. Although national unemployment rates fell 9 percent from January

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1985 to January,1986, unemployment rose an average of 10 percent in five of the states studied and fell in only two.

Rising unemployment and financial stress are taking their toll on rural Americans and straining social service facilities. A regional mental health center in southwest Minnesota reports outpatient services up 30 percent since 1984; 24 hour crisis intervention activities are up over 300 percent; and substance and family abuse consultations are up 67 percent. Similarly, overall social service demands are up 30 percent in northern Iowa, despite declining population.

DIM PROSPECTS FOR STATE AID: Financially stressed local governments can expect little added assistance from their states. State tax bases also depend on the health of the agricultural economy, and many states are under severe budgetary stress. Six of the eight study states had tax revenues grow more slowly than the national average in fiscal 1985, 1986, or both. There were absolute declines in revenues in four of those states in either 1985 or 1986. Six of the states surveyed were forced to take the extreme step of making mid-year reductions in their fiscal 1986 budgets.

FEDERAL AID CUTS COMPOUND THE FISCAL SQUEEZE: Federal aid reductions, past and prospective, are compounding the impact of the farm crisis on local governments. Between 1982 and 1984, federal aid to general purpose local governments, excluding General Revenue Sharing, rose by .1 percent nationwide. In the

eight agriculturally dependent regions examined in this study, federal aid actually declined by 18 percent during that same period.

The proposed elimination of revenue sharing will hit rural local governments twice as hard as the average locality. Revenue sharing comprised 44.5 percent of all federal aid received by agriculturally dependent local governments, but only 21.8 percent of the federal aid received by all general purpose local goverments.

POLICY RESPONSES: The fiscal bind confronting rural governments is both immediate and long term. In the short run the difficulties stem from the rapid rise in property tax delinquencies. The resulting cash flow problems are being compounded by reductions in state and federal aid.

Ultimately, the most serious problems will be posed by the dramatic declines in farm land values. But, because assessed values in most states have only begun to reflect the steep fall in market values, serious long term erosion in public services can still be avoided if prompt actions are taken at all levels of government. For local governments this means continuing efforts to "do more with less," although there is evidence that many have already exhausted the efficiency gains from cutback management. For state governments, it means diversifying and broadening the tax base, and attempting to maintain a constant level of state aids through tough fiscal times. For the federal government it means preserving a leaner, more targeted version of general aid

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to local governments and maintaining those portions of the tax code that support local economic development and self-help.

The farm crisis ranks among the most severe regional economic recessions since the 1930s. If left unchecked, it has the potential to seriously--and in some cases permanently--undermine the fiscal foundations of many rural communities. But, intelligent policy decisions made before the situation worsens, can ease the impacts of transition to a more stable agricultural economy, and rural local governments can avoid becoming another victim of the farm crisis.

I

NRECA NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
1800 Massachusetts Avenue, N.W., Washington, D.C. 20036
Telephone: (202) 857-9500

HD/AP/IGR: Please help - I'm not sure who's responsible for briefing on this. I'm sure it's one of you (or some combination of) but I don't know which. Please let me know if it is or isn't you. Thx Jodi

October 3, 1986

The Honorable David Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510
Attn: Jody Mathison

Dear Senator Durenberger:

Thank you so much for agreeing to appear on NRECA's 1986 Cooperative Leadership Orientation Conference program, scheduled to be held Monday, November 17 through Thursday, November 20 at the Washington Hilton Hotel here in Washington, D.C. A copy of the program brochure is enclosed for your information. We expect approximately 135 of our member system general managers, board members, and spouses to attend this program.

You will be giving the luncheon address entitled, "The Federal Government 101: A Lifetime of Learning" on Tuesday, November 18. Please note how we described your presentation on the enclosed one-page outline. We would appreciate it if you could come to the NRECA registration desk outside the Monroe room on the Concourse level by 11:45 a.m. to pick up your name badge. The luncheon will start at 11:45 a.m. in the Thoroughbred room also on the Concourse level. At approximately 12:30 p.m., Bob Bergland, NRECA's General Manager, will introduce you. We would like you to spend approximately one hour addressing the participants' concerns. Bob Kabat, NRECA's Director of Management Services, will moderate this question and answer session. We will be finished at 1:30 p.m.

It is my understanding you have agreed to participate on this program for an honorarium of $2,000, which we will send, per your request, to Pirahna Press in Minneapolis.

I am enclosing several informational pieces on NRECA to provide you additional background on our program, its problems, and its issues. If you have any questions, please call me at 857-9633.

Sincerely,

Bob Lively
Legislative Representative

Enclosures

xc: Barbara D. Roos
Bob Kabat
Margaret Isaac

PIRANHA

PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Mr. Rob Lively
Nat'l Rural Electric Cooperative Assoc.
1800 Massachusetts Avenue NW
Washington, DC 20036

FROM: PIRANHA PRESS

DATE: OCTOBER 7, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

Senator Durenberger has entered into an exclusive arrangement with us under which we handle the arrangements for the sale and promotion of his books as well as his appearances. If you have not already been contacted, you will be contacted by the law firm which represents Senator Durenberger to review the terms of our arrangement with the Senator, the legal restraints, if any, and the fees and travel arrangements for his appearance.

If you have any questions, please contact Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

K

NRECA MANAGEMENT SERVICES

1986 COOPERATIVE LEADERSHIP ORIENTATION CONFERENCE

NOVEMBER 17-20, 1986
Washington Hilton Hotel and Towers
Connecticut Avenue and Columbia Road, N.W.
WASHINGTON, D.C.
(a short walk from NRECA)

(An orientation program for anyone who has become a director or manager within the last five years or has the potential to become a manager within the next few years.)

ALL SESSIONS WILL BE IN THE MONROE ROOM ON THE CONCOURSE LEVEL UNLESS OTHERWISE INDICATED

Monday, November 17, 1986

1:00 - 3:00 pm — EARLY REGISTRATION

3:00 - 6:00 pm — SPECIAL PRECONFERENCE WORKSHOP FOR PARTICIPANTS AND SPOUSES: EXECUTIVE STRESS MANAGEMENT--ARE YOU DYING TO DO A GOOD JOB?

- o What are the physiological factors of stress, and how can these symptoms affect productivity and length of life?
- o Do you have a "Type A" personality? What are the ten danger signals, and what are some of the methods you can employ to reduce the negative effects of stress?
- o Can you recognize "assassins on the job?" Do you take your work problems home, or vice versa, bring your family stresses into the office?

You have a relatively new position. Is your concern about how well you are "measuring up, filling Mr. or Ms. Perfect's shoes" causing you undue anxiety? Ever since you accepted this new role, you had to, and still have to, learn coping skills so that you can deal better with your added responsibilities. This special workshop will teach you and your spouse techniques to deal effectively with personal, family, employee, and organizational stress.

Joseph L. Mancusi, Ph.D., President, Center for Organizational Effectiveness, Alexandria, Virginia

Joe Mancusi is president of a consulting firm he and his wife founded that specializes in management and leadership training, conflict resolution, and organizational effectiveness. He is a clinical psychologist and the former Associate Director of Psychology for the Veterans Administration in Washington, D.C. He has spoken throughout the United States and was a speaker at NRECA's November 1985 Chairman of the Board Conference.

Tuesday, November 18, 1986

7:30 - 8:30 am — REGISTRATION

8:30 - 8:45 am — LOGISTICS AND ANNOUNCEMENTS:
PLANS FOR THE CONFERENCE

Barbara D. Roos, Conference Program Developer, NRECA

8:45 - 9:45 am — VISION OF OUR FUTURE:
YOUR CHALLENGES TO MAKE IT HAPPEN

- Developing a more supportive and committed membership.
- What does it mean to act like a cooperative?
- Mixing with the members--getting to know your members better
- Keys to survival--creating jobs in rural America and meeting changing member needs

Bob Bergland, Executive Vice President and General Manager, NRECA

During this opening presentation, Bob Bergland will discuss the challenges you face, many of which have changed dramatically in the last few years. Your spouse will find that this will give him/her a much better understanding of the major issues you both face as rural Americans.

10:00 -10:15 am — COFFEE AND COKES

10:15 -11:45 am — WORKING WITH NUMBER ONE: EFFECTIVE BOARD/MANAGER INTERACTION

A roundtable discussion with experienced directors, managers and consultants where you should feel free to raise any issues of concern in board/manager relations such as:

M

- o How close should the manager be to the board chairman? Can he or she be too close?
- o How much board participation should there be in the development of the agenda?
- o How much information should the manager give to the board? Is there such a thing as too much?
- o Should the manager encourage the board to question and challenge more often--isn't there some danger in doing this?
- o How can a manager deal with such sensitive issues as compensation and benefits, management succession, etc.?

Come prepared to raise your questions and concerns with:

Jim Vann, Manager, Dixie Electric Cooperative, Union Springs, Alabama; and NRECA Alabama Director
Vince Slatt, P.E., Retired Manager, Inland Power and Light Company, Spokane, Washington
Johnnie Austin, Board Chairman, Blue Ridge Electric Membership Corporation, Lenoir, North Carolina
Neil Doherty, Management Consultant and Former Manager of Management Search, NRECA

11:45 - 1:30 pm GROUP LUNCHEON FOR PARTICIPANTS AND SPOUSES
ADDRESS: THE FEDERAL GOVERNMENT 101--
A LIFETIME OF LEARNING

Senator David Durenberger
(Republican, Minnesota)

Senator Durenberger will be our luncheon guest of honor. Although he will comment on the 1986 election results, the bulk of his time will be devoted to listening to your concerns and answering your questions in areas such as:

- o The economic crisis in rural America -- when will it be over, what can be done about it?
- o How can we save our rural communities, which are so affected by this crisis?
- o What can be done about the adequacy and increasing cost of rural health care?
- o What further impact will Gramm-Rudman have on our schools, our communities, agriculture, etc.?
- o Can we reduce our trade deficits, increase agricultural exports?

N

- o Will we ever again live in a safe and sane world?
- o What can we do about environmental issues such as acid rain?

1:30 - 3:00 pm AVOIDING CONFLICTS OF INTEREST

- o What potential conflicts of interest should you be careful to avoid or disclose as a manager or director?
- o What about a directors' fiduciary responsibility, what about the G&T director?
- o How liable are you as managers and directors?

John Conway, Esquire, Corporate Counsel for Tri-State G&T, and Counsel for the Colorado Statewide, Denver, Colorado

Response by: Tony Williams, Director, NRECA Retirement, Safety, and Insurance Department

3:00 - 3:15 pm COFFEE AND COKES

3:15 - 4:15 pm OPEN FORUM DISCUSSION: ALL YOU WANT TO KNOW ABOUT NRECA--AND MORE

A chance for you and your spouse to raise questions with NRECA's general manager and top staff in areas such as:

- o What can be done about the agricultural crisis?
- o What is the outlook for future financing?
- o What about help in strengthening our member relations, communication involvement?
- o What help can we get from NRECA in marketing?
- o What is NRECA doing to strengthen and improve our employee benefit programs, our insurance coverage, etc.?
- o What is NRECA doing to help us prevent buyouts and sellouts, protect the all power requirements contracts?
- o What changes does NRECA see in the rural electric program in the next five to ten years? What should we do <u>now</u> to get ready for them?

o

Bob Bergland, General Manager, NRECA
Tony Williams, Director, NRECA Retirement, Safety, and Insurance Department
Brad Koch, Director, NRECA Energy and Environmental Policy Department
John Davenport, Director, NRECA Government Relations Department
Bob Nelson, Director, NRECA Public and Association Affairs Department
Martin Lowery, Manager, NRECA Management Services' Training and Consulting Division

Bob Kabat, Director, NRECA Management Services Department, Moderator

Do come with your questions and concerns about NRECA--there will be no speeches--your questions and concerns will be the open forum.

4:15 - 5:30 pm — SHORT WALK TO AND TOUR OF YOUR NATIONAL HEADQUARTERS

Three staff members of the Management Services Department will take groups of approximately 20 managers, directors, and spouses each on a tour of our building at 1800 Massachusetts Avenue. You will see where each department carries on their operations and learn about the history of NRECA's headquarters and the design of the building. We promise you will never again feel lost in our maze of hallways!

5:30 - 6:45 pm — NRECA RECEPTION IN BOARD ROOM

A chance to visit with your fellow directors, managers, and their spouses, as well as the NRECA staff. This will be a great opportunity for you and your spouse to connect the face to the name to the job title to the department! Don't miss it.

Wednesday, November 19, 1986

7:00 - 8:30 am — CONCURRENT CONTINENTAL BREAKFAST PROBLEM IDENTIFICATION MEETINGS: IF I HAD MY WAY, I WOULD...

We will break into two groups; one just for directors , the other just for managers. Problems and concerns distinct to each will be discussed with an experienced NRECA consultant. We would like each group to come out of these separate sessions with specific items they would like to see changed in their relationship with the board or manager.

P

8:30 - 10:00 am — KEY LEGAL AREAS ABOUT WHICH ALL DIRECTORS AND MANAGERS SHOULD BE AWARE

- o Legal nomenclature--what are the technical terms frequently used in contracts with which you should be familiar?
- o What are the important legal principles and provisions that should be included in your bylaws?
- o What are the restrictions, obligations, rules, and regulations governing borrower/lender relations?
- o When can you resort to wholesale power contracts, tariffs, and rate schedules in buyout/sellout attempts?
- o The legalities surrounding nonprofit status

Bill Crisp, Partner, Crisp, Davis, Schwentker, Page & Currin, Raleigh, North Carolina
John Conway, Esquire, Corporate Counsel for Tri-State G&T, and Counsel for the Colorado statewide, Denver, Colorado

10:00 - 10:15 am — COFFEE AND COKES

10:15 - Noon — THE MEMBERS WANT TO KNOW: COMMUNICATING WITH AND INVOLVING A MORE ASSERTIVE AND QUESTIONING MEMBERSHIP

An open forum discussion where you can raise <u>your</u> questions and concerns about sensitive member relations issues such as:

- o Can we tell the members too much?
- o How open should our board meetings be?
- o How much time should a director or manager spend getting out and mixing with the members? How important is this?
- o How can we get our employees to be more member oriented, more sensitive to member needs and concerns?
- o Which is most important--rates, reliability of service, or services to meet changing member needs?
- o To what information should members have access?

Doyle Hines, Manager, Guadalupe Valley Electric Cooperative, Gonzales, Texas

Paul Weatherby, General Manager, Cobb Electric Membership Corporation, Marietta, Georgia
Dick Pence, Manager of Special Programs, NRECA
Bill Crisp, Partner, Crisp, Davis, Schwentker, Page & Currin, Raleigh, North Carolina

Noon - 1:15 pm — LUNCH ON YOUR OWN

1:15 - 2:45 pm — AN INSIDER'S VIEW OF CONGRESS

A roundtable discussion with three top congressional assistants and an individual who lobbies on your behalf. They will discuss how the legislative process works, from the way legislation moves through Congress to how you can influence the process. The role of committees, the need for coalitions, the impact of political action funds, the ways you can best be heard, the effectiveness of lobbyists, the continuing contact you should have with your members of Congress--these are the types of questions that will be addressed. You should bring all your questions and concerns to this very important session.

Charles Hilty, Minority Staff Director, House Committee on Agriculture
Martha Phillips, Minority Staff Director, House Committee on the Budget
Robert Rozen, Tax Legislative Assistant to Senator George Mitchell (D-ME)
Rob Lively, Legislative Representative, NRECA

3:00 - 3:30 pm — BUS FOR PARTICIPANTS AND SPOUSES TO CFC

3:30 - 4:15 pm — YOUR CO-OP FINANCE ORGANIZATION: THE BUCK STARTS HERE

- Relationship to REA: Here Today, Gone Tomorrow?
- Take an interest in "interest" because we need to remember that money does not grow on trees!

The National Rural Utilities Cooperative Finance Corporation (CFC) is the money lending institution about which you as a new director or manager should be well informed. Their financial process, history, and future will be discussed by the individual most knowledgeable regarding your system's financing considerations, Chuck Gill. This will be a presentation you cannot afford to miss.

Charles B. Gill, Governor and Chief Executive Officer, CFC

R

4:15 - 5:15 pm ORIENTATION TOUR OF CFC FOR DIRECTORS, MANAGERS, AND SPOUSES

CFC's national headquarters are located in historic Georgetown. You will hear a brief orientation followed by a tour of the building to see the CFC staff at work.

5:15 - 6:30 pm CFC RECEPTION

Immediately following your tour of the CFC building, participants are invited to enjoy a reception hosted by CFC. You will enjoy the company of fellow participants as well as CFC and NRECA staff members. After the reception, feel free to walk around historic Georgetown, have dinner, and shop. You will be given a list of nearby restaurants and some information about things to see in this very vibrant and interesting section of your nation's capital.

Thursday, November 20, 1986

7:00 - 8:30 am CONCURRENT CONTINENTAL BREAKFAST PROBLEM IDENTIFICATION MEETINGS: IF I HAD MY WAY, I WOULD...

We will break into two groups; one just for directors, the other just for managers. Problems and concerns distinct to each will be discussed with an experienced NRECA consultant. We would like each group to come out of these separate sessions with specific items they would like to see changed in their relationship with the board or manager.

8:30 - 10:15 am OPEN FORUM DISCUSSION: DEALING WITH TOUCHY EMPLOYEE AND LABOR RELATIONS ISSUES

- o How can you be sure you are compensating your employees equitably? How can you make sure you are competitive?
- o How can mutual understanding and acceptance between the board and manager be achieved in this occasionally difficult area?
- o How can employee understanding and acceptance that they are being paid equitably and competitively be achieved?
- o What impact will tax reform have on employee benefits?
- o What's new in employment at will, drug and alcohol testing, and discrimination?

S

- o Some do's and don'ts for labor negotiations.
- o What is the board's role in all of the above?

Jack Williams, Director, Southern Maryland Electric Cooperative, Inc., Hughesville, Maryland; and NRECA Secretary/Treasurer
Jim Kiley, General Manager, Sioux Valley Empire Electric Association, Colman, South Dakota
Pat Peyser, NRECA Senior Management Consultant
Betty Southard Murphy, Partner, Baker & Hostetler, and past chairman, National Labor Relations Board
Rob Lively, NRECA Legislative Representative

10:15 - 10:30 am — COFFEE AND COKES

10:30 - Noon — IT'S NOT EASY GETTING THE BOARD TO APPRAISE THE MANAGER

- o What are some approaches that work?
- o Who should do the appraisal--the whole board or a committee?
- o Why are boards reluctant to appraise their managers? What can be done to make them more comfortable about doing this?

Jim Kiley, General Manager, Sioux Valley Empire Electric Association, Colman, South Dakota
Jack Williams, Director, Southern Maryland Electric Cooperative, Inc., Hughesville, Maryland; and NRECA Secretary/Treasurer
Neil Doherty, Outside Consultant and Former Manager of Management Search, NRECA

Noon - 2:15 pm — GROUP LUNCHEON FOR PARTICIPANTS AND SPOUSES
ADDRESS: ELECTION AFTERMATH--WHAT NOW?

Elizabeth Drew, Journalist and Television Commentator, Washington, D.C.

Elizabeth Drew will present her views on the November election results and how they might influence the 1988 presidential race. She will discuss the winners, the losers, and what key issues may come up during the next congress. She will also give us her ideas on the impending domestic and international issues that will effect each of us, our members, and the political future of our country. Elizabeth Drew is a widely acclaimed journalist and

television commentator. She is a regular panelist on "Agronsky & Company," and also appears frequently on "Face the Nation," and "Meet the Press." She has authored six books on the American political climate, and is the Washington Correspondent for New Yorker Magazine. She was a member of the panel for the first Ford/Carter debate and she is highly qualified to discuss the tough issues our country faces. Her knowledge and perceptive analyses of Washington's movers and shakers make her one of our country's most sought-after speakers.

2:15 pm GROWING AND DEVELOPING TOGETHER

Bob Kabat, Director, NRECA Management Services

Wednesday, November 19, 1986

7:30 - 2:30 pm SPOUSES TOUR: SEE THE FREQUENTLY UNSEEN SIGHTS!

Most museums, monuments, and memorials you will see on your own time. This tour has been developed especially for NRECA spouses to encompass some sights frequently missed by the tourist on their own. Your bus will pick you up bright and early for a full day in your nation's capitol. We will start out with an early morning private tour of the White House. Next we will gain special admittance to the State Department and see their fine collection of early American furnishings. From there our tour guide will point out the many memorials and museums on our way to the Library of Congress, where you will have time to walk through this majestic building and view their collection. Our next stop will be the Kennedy Center for the Performing Arts. There you can take in the famous Hall of Nations and spectacular rooftop views of both the Potomac River and the Washington skyline. We will enjoy a delicious boxed luncheon on our way up "Embassy Row" to the Washington Cathedral, breathtaking in its majestic architecture. After a tour through this peaceful and beautiful building, our bus will take us back to the hotel in time to freshen up before our 3:00 p.m. trip to CFC headquarters. Wear comfortable shoes and clothing and see D.C. like a native! Make sure you indicate on the enrollment form how many from your party will be joining in on this tour.

NRECA NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
1800 Massachusetts Avenue, N.W., Washington, D.C. 20036
Telephone: (202) 857-9500

November 24, 1986

Ms. Jody Mathison
Office of The Honorable David Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Mathison:

On behalf of the attendees of NRECA's 1986 Cooperative Leadership Orientation Conference, I would like to thank Senator Durenberger for participating on this program. His luncheon address was very well received and the participants appreciated him taking time out of his busy schedule to come speak to them about their needs and concerns.

Per your instructions, the Senator's honorarium has been sent to Pirahna Press in Minneapolis to the attention of Mr. Gary Diamond. If you have any questions about the conference do give NRECA's Program Developer, Barbara Roos, a call at 857-9662.

Sincerely,

Rob Lively
Legislative Representative

v

NRECA NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
1800 Massachusetts Avenue, N.W., Washington, D.C. 20036
Telephone: (202) 857-9500

November 26, 1986

Mr. Gary Diamond
Pirahna Press
4504 Excelsior Boulevard
Minneapolis, Minnesota 55416

Dear Mr. Diamond:

Per the instructions from Ms. Jody Mathison of Senator David Durenberger's staff, enclosed please find an NRECA check in the amount of $2,000 which covers the Senator's honorarium for speaking on our 1986 Cooperative Leadership Orientation Conference program on Tuesday, November 18. We do appreciate the Senator's participation.

Please contact me if you have any questions.

Sincerely,

Barbara D. Roos

Barbara D. Roos
Conference Program Developer

xc: Ms. Jody Mathison
Mr. Rob Lively, NRECA
Legislative Representative

Enclosure

NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
1800 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036
PHONE (202) 857-9500

080091

DATE 11/26/86 CHECK NO. 0080091 PAY

AMOUNT $*****2,000.00

TWO THOUSAND AND 00/100 DOLLARS

PAY TO THE ORDER OF

PIRAHNA PRESS
4504 EXCELSIOR BOULEVARD
MINNEAPOLIS MN 55117

NATIONAL RURAL ELECTRIC COOPERATIVE ASSN

Robert D. Bergland
AUTHORIZED SIGNATURE

Teresa D. Kallbake
AUTHORIZED SIGNATURE

⑈080091⑈ ⑆054000030⑆ 45⑈090500559⑈

November 28, 1986

Honorable David Durenberger
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

Your luncheon address at our Cooperative Leadership Orientation Conference on November 18 was very well received. You dealt with the issues and concerns our people are most interested in.

I think it also gave you a further insight into the deep concerns about the rural economy. As you pointed out, it really was an educational day, not only for those attending, but for you.

We appreciate so much your being there in view of what obviously was a busy day for you.

Sincerely,

Bob Bergland
General Manager

BB:sba

x

Jody Mathison

SPEAKER AGREEMENT FORM

PROGRAM: 1986 CLOC

RESPONSIBILITY OF: Roos/Isaac

NAME/TITLE: The Honorable David Durenberger (Senator)

ORGAN/ADDRESS: SR154 Russell SOB

CITY/STATE/ZIP: Wash DC 20510

PHONE NO: 224-3244

* SOCIAL SECURITY NO: 471 36 4210

DATE/TIME: Tues 11/18 11:45a - 1:30pm Luncheon address

TITLE OF SPEECH/PANEL: Fed Govt 101- Lifetime of Learning

SLEEPING ROOM REQS: —

SET UP/AV REQS:

SPECIAL REQS:

DC MEETING: —

BOOK PURCHASE: —

ON SITE MEETING: —

FUNCTIONS ATTENDING: just his lunch

BUREAU USED: —

CONF LETTER SENT: 10/31 0570C

FINANCIAL AGREEMENT: $2K to Pinchot Press 4504 Excelsior Blvd Mpls MN 55416 Attn Gary Diamond

INVOICE RCVD/PAID: to cathy 11/18

COMMENTS: all correspondence thru Lively First said no then changed mind 4 wks out; DONT USE AGAIN! Bergland supports contenc in next election. His lawyer Rdo Cromartie x Tal tried to ↑ honorarium one week out & get us to buy CLIFF OUSE copies of his book. Also tried thru staff to leave 15 mins early (req denied diplomatically,

HOME OFFICE MEMORANDUM

TO: Jim Medeiros DATE: August 31, 1984

FROM: James A. Gallaher EXT: 2756

SUBJECT: The Washington Campus

I've reviewed the materials on The Washington Campus for NEL's Advanced Management Program with Gordon and Donna, and would make the following suggestions:

Topics. A general session on "How Congress Works" and the relationship between Congress and the President would be helpful. In addition, the role of corporations, trade associations, and lobbyists in the legislative process might be included.

As to specific topics, I think discussion of issues most important to our industry would be useful: taxation, financial services reform, pensions, and employee benefits.

Speakers. Among those Congressmen and Senators who could address our specific industry topics would be Senators Riegle, Mitchell, Packwood, Bradley, Durenburger, and Garn as well as Congressmen Rostenkowski, Gephardt, Jones, Moore, and Gradison. There are numerous others we could suggest as generalists.

You also might want to consider a top staff person (Kirk O'Donnell from Speaker O'Neill's office or Werner Brandt of Congressman Foley's office) to discuss the legislative process.

Hope these ideas help. Please feel free to call if you have any questions or if we can be of assistance.

/lc
cc: G. MacKay
D. Pignatelli

SPECIAL
COUNSEL
HEARING
EX. 176

A

The Washington Campus

2820 P Street, N.W.
Washington, D.C. 20007

202/338-6803

Member Institutions
Arizona State University
University of California, Berkeley
University of California, Los Angeles
Cornell University
Dartmouth College
Georgetown University
Grand Valley State Colleges
Howard University
Indiana University
The University of Michigan
The University of New Mexico
The University of North Carolina at Chapel Hill
The Ohio State University
Purdue University
The University of Texas at Austin

September 13, 1984

Dr. James A. Medeiros
Second Vice President,
Organization and Development
New England Mutual Life Insurance Company
501 Boylston Street
Boston, MA 02117

Dear Jim:

Just a note to follow up our **August 21 meeting** with you, Gail Euga, Jim Gallaher, and Joan Zilch.

The Washington Campus has agreed to plan and conduct a three-**day, three-night program in Washington**, D.C. on April 10-12, 1985. We will work with you, and with Jim Gallaher, in planning the program. Together we will decide on the final format.

Our registrar, Eleanor Suntum, will consult with Joan Zilch on administrative arrangements and we have already reserved rooms at the Marbury House Hotel in Georgetown, in the event that you prefer such accommodations to those at the Ramada Renaissance Hotel.

I was pleased with our discussion of potential speakers and will look forward to having Jim Gallaher's suggestions. Once I have those, I will prepare a draft program, cost it out, and get it back to you for your reaction, probably in late October.

All of us at The Washington Campus are delighted to be working with New England Life and we look forward to an outstanding program. With many thanks and best wishes,

Sincerely,

Thomas W. Carr
Vice President

TWC:lrb

P.S. Hope you can come to our open program October 14-19.

The Washington Campus

2020 P Street, N.W.
Washington, D.C. 20007
(202) 785-8051

March 21, 1985

The Honorable David Durenberger
United States Senator
375 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

This April The Washington Campus will be arranging a seminar in Washington for twenty executives in New England Life's Advanced Management Program. We would very much appreciate your speaking with the group during their stay in Washington April 9-12. We hope that a luncheon meeting on Wednesday, ~~April 10 beginning at 12:00 Noon~~ in the Russell Senate Office Building might be convenient to your schedule, but we would be pleased to schedule the meeting at another time during the program should that be better for you. There would be ~~a $1,000 honorarium for the presentation~~.

I will call your office to follow up on this request in the near future. Thank you for your consideration.

Sincerely,

Terry R. Zack
Executive Director

TRZ:bk
Enclosures

cc: Gordon P. MacKay

Mike M.
This has been accepted for $1K. You or Sue should call about sending check for $1. to Piranha Press.

The Washington Campus

2020 P Street, N.W.
Washington, D.C. 20007

202-[illegible]

Member Institutions
Arizona State University
University of California, Berkeley
University of California, Los Angeles
Carnegie-Mellon University
Dartmouth College
Georgetown University
Grand Valley State Colleges
Howard University
Indiana University
The University of Michigan
The University of New Mexico
The University of North Carolina at Chapel Hill
The Ohio State University
Purdue University
The University of Texas at Austin

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS

A Program For
New England Mutual Life Insurance Company

April 9 - 12, 1985
Washington, D.C.

LIST OF PARTICIPANTS

Kathleen O. Angel
Dir. of Nat'l Accts.
Large Case Marketing

James G. Beaton
Second Vice President
Corp. Adm. Services

Michele Bolden
Director
Contract Change Svcs. Adm.

Robin L. Cohen
Director
Underwriting Admin.

James S. Cruickshank
Second Vice President
Individual Pension Mkt. Svcs.

William F. Cummings
Assistant Vice President
Financial Planning Admin.

Roy C. Dickover
Second Vice President
Group Pension Mkt. Svcs.

Anne Marie Faria
Director
Personnel Services

Thom Faria
Second Vice President
Agency Operations Admin.

Karen B. Formal
Director
Group Pension Marketing Svcs.

Joel H. Goober
Assistant Vice President
Group Marketing Admin.

Peter N. Harrington
Assistant Vice President
Public Affairs

Robert T. Koontz
Associate Controller
Fin. Anal. & Report. Adm.

Chester T. Lewandowski
Associate Actuary
Actuarial

D

LIST OF PARTICIPANTS
Page Two

Stephen W. Mitchell
Assistant Vice President
Group Pension Defined
Contribution Adm.

John P. Riley
Assistant Vice President
Financial Information Sys.

Charles M. Ryder
Assistant Officer
Individual Product Mkt. Svcs.

Ellen D. Sullivan
Counsel & Assistant Secry.
Law Department

Thomas J. Tagliamonte
Vice President
NELESCO

Sherry A. Umberfield
Second Vice President
Financial Executive

March 29, 1985

Carole
Rules Committee
Sr305

Dear Carole:

Thank you for reserving room SR188 for our office. We will be using the room from 8:45 until 9:45, on the morning of Thursday, April 11, 1985.

There will be 23 people from the Washington Campus using the room at this time.

Again, thank you for your help. Have a nice day!!

Sincerely,
Mary
Mary Friske
Office of Senator Dave Durenberger

APPROVED: Charles McC. Mathias Jr.
Chairman, Committee on
and Administrati

DATE: 4/1/85

4/1

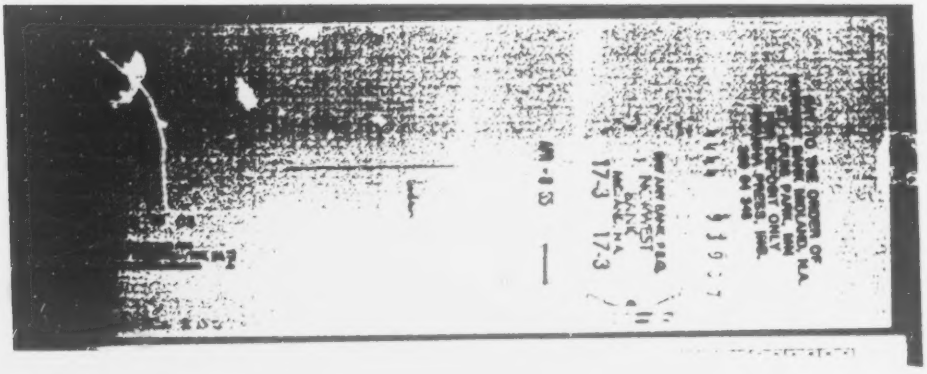
(NOTE: All food and nonalcoholic beverages MUST be catered by the Senate Restaurant.)

F

	BALANCE BROUGHT FORWARD	12,493	25
3581 April 3, 19 85			
TO Piranha Press			
FOR 2001=Durenberger Honorarium	DEPOSITS		
	TOTAL		
	AMOUNT THIS CHECK	1,000	00
	BALANCE	11,493	25
3582 April 4, 19 85			
TO Jerry Lewis			
FOR 701 DIRECT DEPOSIT—4/3/85 COA 105—Ready Assets Transfer	DEPOSITS	30,000	00
	TOTAL	41,493	25
	AMOUNT THIS CHECK	500	00
	BALANCE	40,993	25
3583 April 4, 19 85			
TO Restaurant Associates			
FOR 1704-Deposit for dinner on 4/10/85	DEPOSITS		
	TOTAL		
	AMOUNT THIS CHECK	521	10
	BALANCE	40,472	15

G

April 3,
Pay to the order of
Dollars
For
Thomas A. Edison
from Jean Durenberger
⑆021400080⑆ ⑈0900 2970⑈01⑈ ⑈0000100000⑈



The Washington Campus

2020 P Street, N.W.
Washington, D.C. 20007

202 338-6603

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The University of North Carolina at Chapel Hill
The Ohio State University
Purdue University
The University of Texas at Austin

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS

A PROGRAM FOR
NEW ENGLAND MUTUAL LIFE INSURANCE COMPANY

TUESDAY, APRIL 9 - FRIDAY, APRIL 12, 1985
WASHINGTON, D.C.

AGENDA

TUESDAY, APRIL 9, 1985

Afternoon	ARRIVAL AND CHECK-IN The Georgetown Marbury House 3000 M Street, N.W. Washington, D.C. 20007 (202) 726-5000
3:30 p.m. Sheffield/Stafford Rooms Marbury House	WELCOME Mr. John A. Fibiger, FSA President New England Mutual Life Insurance Company
	A WASHINGTON PERSPECTIVE Mr. Loren Belker Administrative Assistant Office of Senator J. James Exon
5:00 p.m.	Recess
6:30 p.m.	COCKTAIL RECEPTION AND OPENING DINNER The Georgetown Marbury House Exeter/Berwick Rooms Second Floor

J

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE TWO

TUESDAY, APRIL 9, 1985 [CONTINUED]

8:15 p.m. INTRODUCTORY REMARKS

Mr. Thomas W. Carr
Vice President
The Washington Campus

Evening Speaker

BAD NEWS, GOOD NEWS, AND
OUR POLITICAL FUTURE

Mr. Ben J. Wattenberg
Senior Fellow
American Enterprise Institute

Co-Editor
Public Opinion

9:15 p.m. Recess - Hospitality Suite

K

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE THREE

WEDNESDAY, APRIL 10, 1985

7:30-8:30 a.m. Lower Half Restaurant Marbury House	Buffet Breakfast
8:30 a.m.	DEPART FOR CAPITOL HILL
9:00 a.m. Room 321 Hart Senate Office Building	THE ORGANIZATION OF THE CONGRESS AND THE ROLE OF THE MEMBERS Dr. Kevin C. Gottlieb Executive Assistant and Senior Policy Advisor Office of Senator Donald W. Riegle, Jr. Professor, Department of Social Science Michigan State University Former Senior Aide to Senators Ford, Nelson and Cranston
10:30 a.m.	Break
10:45 a.m.	THE ROLE OF LOBBYISTS AND INTEREST GROUPS The Honorable Tom C. Korologos Vice President and Director of Legislative Affairs Timmons & Company, Inc. Former Deputy Assistant to the President for Senate Relations
11:45 a.m.	Depart for Luncheon
12:00 Noon Room 385 Russell Senate Office Building	THE 99TH CONGRESS AND THE POLICY PROCESS Dr. Norman J. Ornstein Resident Scholar American Enterprise Institute Professor of Politics Catholic University of America
1:45 p.m.	Depart for Committee Hearing Room

L

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE FOUR

WEDNESDAY, APRIL 10, 1985 [CONTINUED]

2:00 p.m.	THE LEGISLATIVE PROCESS AND THE ROLE OF COMMITTEES AND HEARINGS Dr. Kevin C. Gottlieb
2:45 p.m.	Break
3:00 p.m. Room 321 Hart Senate Office Building	THE BUDGET PROCESS The Honorable W. Bowman Cutter Partner Coopers and Lybrand Former Executive Associate Director of Budget Office of Management and Budget
4:15 p.m.	Break
4:30 p.m.	THE CONGRESS AS A GOVERNING BODY: CURRENT BUDGET AND TAX ISSUES The Honorable Barber B. Conable, Jr. Visiting Scholar American Enterprise Institute Former United States Representative New York
5:30 p.m.	RETURN TO HOTEL
6:00 p.m.	Break
6:20 p.m.	DEPART FOR THE KENNEDY CENTER
6:30 p.m.	DINNER Roof Terrace Restaurant The John F. Kennedy Center for the Performing Arts Washington, D.C. (202) 833-8870
8:00 p.m.	"MY ONE AND ONLY" Kennedy Center Opera House
10:30 p.m.	RETURN TO HOTEL
10:45 p.m.	Recess - Hospitality Suite M

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE FIVE

THURSDAY, APRIL 11, 1985

7:30-8:15 a.m. Lower Half Restaurant Marbury House	Buffet Breakfast
8:15 a.m.	DEPART FOR CAPITOL HILL
8:45 a.m. Room 188 Russell Senate Office Building	A SENATOR'S PERSPECTIVE The Honorable David Durenberger United States Senator Minnesota
9:45 a.m.	DEPART FOR OLD EXECUTIVE OFFICE BUILDING 17th and Pennsylvania Avenue, N.W. [DRIVER'S LICENSE REQUIRED FOR ADMITTANCE]
10:15 a.m. Room 476 Old Executive Office Building	THE REAGAN WHITE HOUSE AND THE POLICY-MAKING PROCESS The Honorable Roger B. Porter Deputy Assistant to the President for Policy Development Director of the Office of Policy Development
11:15 a.m.	DEPART FOR DEPARTMENT OF COMMERCE Secretary's Entrance 15th Street and Constitution Avenue, N.W. Washington, D.C.
11:30 a.m. Room 4830 Department of Commerce	THE FORMATION OF ECONOMIC POLICY: AN OUTLOOK FOR BUSINESS The Honorable Sidney L. Jones Under Secretary of Commerce for Economic Affairs
12:30 p.m. Room 5843 Department of Commerce	Luncheon Secretary's Dining Room Department of Commerce

N

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE SIX

THURSDAY, APRIL 11, 1985 [CONTINUED]

1:30 p.m. — DEPART FOR NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

1120 G Street, N.W.
Washington, D.C.
(202) 347-3190

1:45 p.m.
Conference Room
National Academy of Public Administration

BUREAUCRATS AND THE BUREAUCRACY

Mr. Don Wortman
Acting Executive Director
National Institute of Public Affairs

Former Deputy Director for Administration
Central Intelligence Agency
Former Acting Commissioner and
Deputy Commissioner
Social Security Administration
Former Deputy Assistant Secretary
Department of Health and Human Services

2:45 p.m. — DEPART FOR WEXLER-REYNOLDS

1317 F Street, N.W.
Washington, D.C.
(202) 638-2121

3:00 p.m.
Sixth Floor
Wexler-Reynolds

THE IMPORTANCE OF COALITION BUILDING

The Honorable Anne Wexler
Chairman
Wexler, Reynolds, Harrison and Schule, Inc

Former Assistant to the President
for Public Liaison

3:30 p.m. — WORKING WITH THE EXECUTIVE BRANCH

Ms. Nancy Reynolds
President
Wexler, Reynolds, Harrison and Schule, Inc

Former Vice President
Bendix Corporation

4:00 p.m. — Discussion

The Honorable Anne Wexler
Ms. Nancy Reynolds

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE SEVEN

THURSDAY, APRIL 11, 1985 [CONTINUED]

4:30 p.m.	Break
4:45 p.m. Sixth Floor Wexler-Reynolds	THE EXECUTIVE DECISION-MAKING PROCESS The Honorable Stuart E. Eizenstat Partner Powell, Goldstein, Frazer & Murphy Former Assistant to the President for Domestic Affairs Former Executive Director Domestic Policy Staff
5:45 p.m.	DEPART FOR CAPITOL HILL CLUB 300 First Street, S.E. Washington, D.C. (202) 484-4590
6:15 p.m. Private Dining Room #1 Capitol Hill Club	RECEPTION AND BANQUET WELCOME Mr. Edward E. Phillips Chairman and Chief Executive Officer New England Mutual Life Insurance Company Evening Speaker THE AGENDA AND OUTLOOK FOR THE NEW ADMINISTRATION The Honorable David R. Gergen Visiting Fellow in Communications American Enterprise Institute Former Assistant to the President for Communications
8:30 p.m.	RETURN TO HOTEL
9:00 p.m.	Recess - Hospitality Suite

P

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE EIGHT

FRIDAY, APRIL 12, 1985

8:00 a.m.	MEET IN HOTEL LOBBY TO WALK TO FOUR SEASONS HOTEL 2800 Pennsylvania Avenue, N.W. Washington, D.C. 20007 (202) 342-0444
8:05 a.m. Douglass Room Four Seasons Hotel	BREAKFAST THE INSURANCE INDUSTRY AND THE ROLE OF THE TRADE ASSOCIATION The Honorable Richard S. Schweiker President American Council of Life Insurance Former Secretary of Health and Human Services Former United States Senator Pennsylvania
9:15 a.m.	RETURN TO MARBURY HOUSE
9:30 a.m. Sheffield/Stafford Rooms Marbury House	GOVERNMENT REGULATION: AN OVERVIEW Dr. Paul R. Portney Senior Fellow Resources for the Future Former Senior Staff Economist Council on Environmental Quality
10:30 a.m.	Break
10:45 a.m.	"H.R. 6161: AN ACT OF CONGRESS" Film
12:00 Noon Lower Half Restaurant Marbury House	Luncheon

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
AGENDA
PAGE NINE

FRIDAY, APRIL 12, 1985 [CONTINUED]

1:00 p.m. Sheffield/Stafford Rooms Marbury House	CORPORATE PARTICIPATION IN THE PUBLIC POLICY PROCESS Dr. Gerald D. Keim Associate Professor of Management College of Business Administration Texas A&M University CLOSING REMARKS Ms. Terry R. Zack Executive Director The Washington Campus
2:30 p.m.	Adjournment

R

THURSDAY, APRIL 11, 1985

8:45am	meet w/Washington Campus, New England Life executives, SR188
9:45am	Meet w/Bernie
12:30pm	luncheon speech to the Council of Medical Specialty Societies, L'Enfant Plaza Hotel
2:15pm	PHOTO, Senate steps, MN Senior Citizens
2:30pm	Meet w/Swedish American Chamber of Commerce (30-40) re: budget deficit dilemma
3:00pm	Meet w/CloseUp, SD106
3:15pm	PHOTO w/Jacobson family in office
3:30pm	Meet new Intelligence Committee staff members
5:00pm	PHOTO on steps w/Know American MN group
5:15pm	depart for airport
5:55pm	NW#85 to Minesota
7:27pm	arrive Minnesota

The Washington Campus

2820 P Street, N.W.
Washington, D.C. 20007

202/338-6603

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Harvard University
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The University of Michigan
The University of New Mexico
The University of North Carolina at Chapel Hill
The Ohio State University
Purdue University
The University of Texas at Austin

April 17, 1985

Dr. James A. Medeiros
Second Vice President
Organization and Development
New England Mutual Life Insurance Company
501 Boylston Street
Boston, Massachusetts 02117

Dear Jim:

It was a real pleasure working with you and Joan on our first program for New England Life. I also enjoyed meeting John Fibiger and seeing Gail Weber again. You have a terrific group! As promised, we will be sending copies of the participants' remarks and evaluations of the seminar, which were all most favorable.

I am enclosing our invoice for the program. Please let me know if you have any questions or would like additional information. I look forward to talking with you in the weeks ahead and to working with you on our next program for New England Life.

With all best wishes,

Sincerely,

Terry

Terry R. Zack
Executive Director

TRZ:bk
Enclosure

T

P/B

The Washington Campus
2620 P Street, N.W.
Washington, D.C. 20037
202 338-6803

COMP	ACCOUNT						SUB ACCOUNT		
0	1	0	3	5	0	7	2	0	

DIV.	DEPT.	PROJECT NUMBER						
1	1	2	6	9	H	R	E	X	D

$13,000 12,750

JOAN E. ZILOH
MAY 16 1985
Program Coordinator
Management Development Program
Arizona State University
University of California, Berkeley
University of California, Los Angeles
Colorado State University
Dartmouth College
Georgetown University
Georgia Institute of Technology
Indiana University
The University of Michigan
The University of New Mexico
The University of North Carolina at Chapel Hill
The Ohio State University
Purdue University
The University of Texas at Austin

Dr. James A. Medeiros
Second Vice President
Organization and Development
New England Mutual Life Insurance Company
501 Boylston Street
Boston, Massachusetts 02117

INVOICE

HOW WASHINGTON OPERATES: THE GOVERNMENTAL PROCESS
April 9-12, 1985
Washington, D.C.

An Executive Program for New England Mutual Life Insurance Company

Fixed Costs for Instruction, Organization, and Administration of Educational Program.....	$23,000*
Less Deposit.....	-10,000
	13,000 ✓
Per person cost for meals, materials, transportation ($375 x 22 participants).....	8,250 ✓
Transportation, meals and tickets - Kennedy Center ($100 x 22 participants).....	2,200 ✓
TOTAL FEE DUE.....	$23,450

4/17/85
GAYLE WEBER
MAY 15 1985
Senior Vice President
Worldwide Executive Services

COMP	ACCOUNT						SUB ACCOUNT		
0	1	0	3	4	5	8	0	0	

DIV.	DEPT.	PROJECT NUMBER						
1	1	2	6	9	H	R	E	X	D

$10,450

JAMES A. MEDEIROS
APR 20 1985
Second Vice President
Organization & Executive Devel.

* $500 additional instructional cost per New England Life

$250

U

0051

ACKERLEY COMMUNICATIONS, INC.

MEMORANDUM

TO: Keith Fitzmann DATE 7/17/85

FROM Mary Robertson

SUBJECT: REQUEST FOR HONORARIUM CHECK

Because of our Company's involvement with Outdoor Advertising Association of America, Inc., Barry has requested that your organization issue a check as follows:

Check for $ 2,000.00

Payable to: David Durenberger, Repub. Senator - Minnesota

For Honorarium for speech on 7/16/85 by _____

Send the check to: Judy Quimby
OAAA
1899 L Street, N.W. Suite 403
Washington, D.C. 20036

Keith -
please Federal Express today. Thanks,
Mary

SPECIAL
COUNSEL
HEARING
EX. 177

A

MANUAL CHECK INPUT SHEET

Vendor No. 9 0 1 3 3

Vendor Name DUKE ENERGY/PCOD

Invoice No. 92525

Invoice Date 0 7 / 1 9 / 8 5

GL No.	4561	----	----	----
Airport	902	---	---	---
Gross Amt.	2600.00	----.--	----.--	------.--

Exp. Mo. 7

Check Date 0 7 / 1 9 / 8 5

Check No. 00525

month codes: jan-1 feb-2 mar-3 apr-4 may-5 june-6 july-7 aug-8 sep-9
oct-0 nov-N dec-D

B

7/15/93	500575	DAVID DURENBERGER/CONGRATULATORY SPEECH ON 7/16/93 4801-900	2000.00	-0-	2000.00

FORM NO. 581

ASHBY-SET ADVERTISING, INC.
P.O. BOX 3643, SEATTLE, WASHINGTON 98124

Mike Mahoney -

The enclosed was received for a speech he ~~made~~ didn't expect an honorarium.

RECEIVED
1985
MAHONEY & CAIRO

SKD,
Let get this
~~Ck. Subs. Fax~~ co to
pay Birmingham ~~etc.~~

MCM

x/2 letting

E

CURTIN, MAHONEY & CAIRNS
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

RICHARD T. CURTIN
MICHAEL C. MAHONEY
JOHN A. CAIRNS
SUSAN L. NEUMEYER
DOUGLAS J. CARNEY
DONNA E. MANSERY
DEANNE M. GRECO
EDWARD C. ANDERSON
MICHAEL W. SCHLEY
JEFFREY C. ROBBINS
KENNETH COREY-EDSTROM
DAVID J. STEINGART

4150 MULTIFOODS TOWER
MINNEAPOLIS CITY CENTER
MINNEAPOLIS, MINNESOTA 55402
TELECOPIER (612) 339-6962
TELEX 29183
TELEPHONE (612) 333-5411

1920 N STREET N.W.
SUITE 420
WASHINGTON, D.C. 20036
TELECOPIER (202) 883-8344
TELEX 64-599
TELEPHONE (202) 887-0718

OF COUNSEL
ALVIN H. GANDAL
ADMITTED IN D.C. AND OHIO

REPLY TO
Minneapolis

August 28, 1985

Mr. Vernon A. Clark
Outdoor Advertising Association
of America, Inc.
Suite 403
1899 L Street N.W.
Washington, D.C. 20036-3881

SENATOR DAVE DURENBERGER--SPEAKING ENGAGEMENTS
OUR FILE NO. 01468-007

Dear Mr. Clark:

Pursuant to our telephone conversation of today, enclosed please find your check in the amount of $2,000 payable to Senator Durenberger for a speaking engagement on July 16, 1985.

Would you please issue a new check payable to Piranha Press, Inc. and forward it to the undersigned.

If you have any questions, please call.

Thank you for your cooperation.

Very truly yours,

SUSAN K. ANDERSON
Legal Assistant

Enclosure

SKA0828851

F

OAAA

9/4/85 Keith

DEAR MARY -

I AM RETURNING THE ENCLOSED CHECK PAYABLE TO DAVID DURENBERGER, AS THEY HAVE REQUESTED IT BE REISSUED PAYABLE TO:

PIRANHA PRESS, INC.

ALSO IN THE AMOUNT OF $2,000.

PLEASE RETURN TO ME AND I WILL FORWARD.

THANKS.

Thanks. Mary Judy

ENCLOSURE

JUDY QUIMBY

National Headquarters (202) 223-5566
OUTDOOR ADVERTISING ASSOCIATION OF AMERICA, INC.
SUITE 403, 1899 L STREET, N.W., WASHINGTON, D.C. 20036-3881

G

ACKERLEY COMMUNICATIONS INC
AIR TERMINAL ADVERTISING
MANUAL REQUEST FOR CHECK

Amount: $ 2000.00

Payable to: Piranha Press, Inc.

Requested by: Ed.
Request date: 10/9/85
Due date: _____
Purchase Order _____

Description: (Honorarium

Special Instructions: To replace ~~lost~~ David Durenberger check.
(Send to Judy Quimby)

Account to be charged: 4801/900

*Note all requests for checks will be entered and run out on the next computer check run, unless manual check is specifically requested.

H

REMITTANCE ADVICE - PLEASE DETACH BEFORE CASHING CHECK NO-62218 No. 031747

DATE	INVOICE NO.	DESCRIPTION	GROSS AMOUNT	DEDUCTIONS	NET AMOUNT
[illegible]	100265	MEMORANDUM	2,000.00		2,000.00
TOTAL					2,000.00

ACKERLEY AIRPORT ADVERTISING, INC.
2001 SIXTH AVENUE • SUITE 3300 • SEATTLE, WA 98121 • (206) 728-0100

ACKERLEY AIRPORT ADVERTISING, INC.
2001 Sixth Avenue • Suite 3300
Seattle, WA 98121
(206) 728-0100

BANK OF CALIFORNIA
SEATTLE, WA

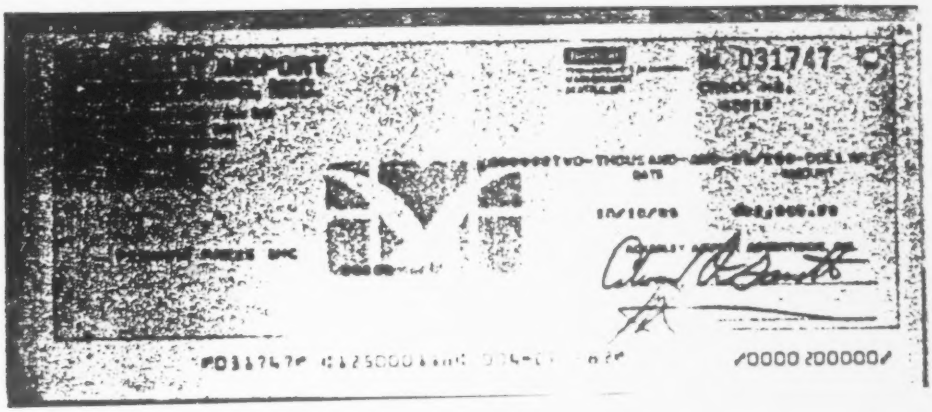
No. 031747
CHECK DATE
62218

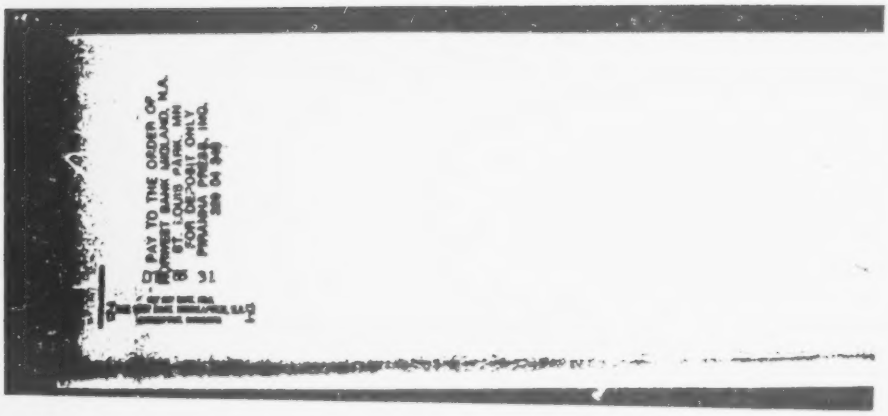
PAY TO THE ORDER OF

PIRANHA PRESS INC

DOLLARS
AMOUNT

$2,000.00




PAY TO THE ORDER OF
MIDWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PRIMARK PRIZE, INC.

oaaa
OUTDOOR ADVERTISING ASSOCIATION OF AMERICA, INC.

OFFICE OF THE PRESIDENT

October 23, 1985

Ms. Susan K. Anderson, Legal Assistant
CURTIN, MAHONEY & CAIRNS
4150 Multifoods Tower
Minneapolis City Center
Minneapolis, MN 55402

Dear Susan:

Enclosed please find a donation in the amount of $2,000.00 payable to Piranha Press, Inc.

This is being sent to you at the request of Senator Dave Durenberger in lieu of honorarium owed to the Senator by our Association.

Please accept our apologies for the tardiness in getting this to you. Apparently the original check payable to the Senator was lost in transit to Ackerley. It had been voided, however, so that will not be a problem.

Sincerely,

Judy Quimby
Secretary to Vernon A. Clark

jq

Enclosure

cc: Hon. Dave Durenberger

National Headquarters
SUITE 403, 1899 L STREET, N. W., WASHINGTON, D. C. 20036 (202) 223-5566

L

M

1985 HONORARIUM

NAME	DATE & PLACE OF SPEECH	AMOUNT	CONTRIBUTED BY
Cong Roy Rowland	6/3/85 OAAA DC	1,000	1,000 Ackerley/Bo
Cn Tip Valentine	6/5 OAAA DC	1,000	1,000 Ackerley/Barry
Cong Jim Trafficant	6/10 OAAA DC	1,000	1,000 Ackerley/Barry
Cong Dean Gallo	7/9 OAAA DC	1,000	1,000 Ackerley/Barry
[illegible]	6/25 OAAA DC	1,000	1,000 Ack. Ley/Barry
[illegible]	6/25 OAAA DC	1,000	1,000 Ackerley/Barry
Bill Richardson	6/10 OAAA DC	2,000	500 Bowlin 1000 Downey/Barry 500 Harold Newman
Cathy Long	7/17 OAAA DC	1,000	1,000 Ackerley/Barry
Tom Harkin	6/5 OAAA DC	2,000	1,000 OAAA 1,000 IOA
Ed Zschau	6/14 OAAA DC	2,000	2,000 Ackerley/Barry
Harold Pryor	6/12 OAAA DC	2,000	2,000 Ackerley/Barry
Tom Luken	6/17 OAAA DC	2,000	2,000 Ackerley/Barry
[illegible]	6/13 OAAA DC	2,000	1,000 [illegible] 1,000 [illegible]
Robert Dole	6/13 OAAA DC	2,000	2,000 Ackerley/Barry
Al D'Amato	7/16 OAAA DC	2,000	2,000 Ackerley/Barry
Al Gore	7/18 OAAA DC	500 1,500	500 [illegible] 1,500 [illegible]
Robert Lee	9/11 OAAA DC	2,000	[illegible]
[illegible] Abraham	9/10 OAAA DC	2,000	[illegible]
Claiborne Pepper	9/9 AAE DC	2,000	1,000 AAF 1,000 AAF
Patricia Feeley	8/14 FOR L.A.	2,000	2,000 Ackerley/Barry
John Seymour	9/9 FOR Wilson Inst. L.A.	2,000	2,000 Ackerley/Barry
[illegible]	9/5 FOR Wilson Inst. L.A.	2,000	[illegible]
Claiborne Pepper	9/9 AAE D.C.	2,000	1,000 AAF 1,000 AAF
Pete Wilson	7/10 NAM DC	2,000	2,000 Ackerley/Barry
Rudy Boschwitz	10/8 Comm VC	1,000	[illegible]
Bob Edgar	10/22 OAAA DC	1,000	[illegible]
Tommy Thompson	10/24 OAAA DC	1,000	[illegible]

TO: KG 4/8 Hold for a while
FROM: JM

SCHEDULING INFORMATION

O.K. if no other offers
Unless w/ KG

SPEECH — 9/17-19 (11th) 11:30
TYPE OF EVENT — EVENT DATE/TIME

Outpatient Ophthalmic Surgery Society — SPEECHES
GROUP NAME — Annual Mtg.

Group Size ~500-1000
~~Honorarium~~ $5K
(amount)

Contact Mike Romansky
Phone 887-8069
Key People _____
_____
_____
_____
_____
Topic _____

Room Set-Up _____
Introduction by _____
Taped _____ (y/n) Transcribed _____ (y/n)

FOLLOW-UP
Thanks Sent 4/24/86 (date)
Photo _____ (y/n) Sent _____ (date)
Photo to Media _____ (date)
Membership Lists
Received _____ (y/n)
Computerized _____ (y/n)
Filed _____ (y/n)
Regret Sent _____
Greeting Sent _____ (y/n)

LOCATION OF EVENT San Diego
Place Town & Country Hotel
Room _____
Phone Number _____
Directions _____

also Kay would like to do fundraising

STAFFING
Briefing Memo _____
Photo _____
Speech CK

MISCELLANEOUS
- All Senators expenses: they will pay Chip's also if he would like to attend
- ~~they~~ will display DD's new book prominantly!

5/16/86
REQUEST DATE

SPECIAL COUNSEL HEARING EX. 178
A

TO: KG
FROM: JM

McDERMOTT, WILL & EMERY
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

ROBERT E. SAGLE, P.C.
CHARLES R. WORK
ROBERT A. WARDEN
TIMOTHY J. WATERS
JAMES H. SNEED
JOHN A. HODGES
MICHAEL A. ROMANSKY
JEANNE A. CARRENTER
ROBERT N. JENSEN
NATHALIE F. P. GILFOYLE
WILLIAM D. ARPLER
WENDY L. KRASNER
R. SARAH COMPTON
J. GARY McDAVID
WALTER A. CAROZZA
CAROLYN KAY WEEDER
DIANE S. MILLMAN
MARY CHERYL MATHES
KURT J. OLSON
DANIEL C. BECKHARD
JACQUELINE E. ZINS
CHERYL L. POLANSKY
ANNE F. STRASSFELD
ELIZBETH R. LEXINSON

COUNSEL
DON E. GRAHAM
RONALD A. BLOCH

1850 K STREET, N. W.
WASHINGTON, D. C. 20006
202 887 8000
TELECOPIER 202 887 8087
TELEX 904261 MCAM WASH

111 WEST MONROE STREET
CHICAGO, ILLINOIS 60603
312 372 2000

ONE POST OFFICE SQUARE
BOSTON, MASSACHUSETTS 02109
617 357 0200

700 BRICKELL AVENUE
MIAMI, FLORIDA 33131
305 358 3500

FIRST NATIONAL BANK BUILDING
SPRINGFIELD, ILLINOIS 62701
217 522 7200

101 NORTH MONROE STREET
TALLAHASSEE, FLORIDA 32301
904 222 2312

ASSOCIATED OFFICE
QIAN MEN HOTEL 513
BEIJING, PEOPLE'S REPUBLIC OF CHINA
332077 TELEX 22523

May 28, 1986

Jodi: can DD do this?

DIRECT LINE
202
887-8069

Mr. Chip Kahn
Legislative Assistant
Office of Senate David Durenberger
147 Russell Senate Office Building
Washington, D.C. 20510

Dear Chip:

I am herewith enclosing correspondence pertaining to the Outpatient Ophthalmic Surgery Society's annual meeting. I believe that this would provide an excellent forum for discussion of the new ambulatory surgery bill with an energetic and aggressive group of advocates. We would also hope that you might be able to accompany the Senator on the trip.

As I mentioned to Jody, we are more than willing to pay whatever honorarium is appropriate as well as all expenses. We would also be more than delighted to provide the Senator with exhibit space in which to market his new publication.

Any "interference" you can run on this issue would be greatly appreciated. If it appears that he definitely will not

Mike would like to have DD tour two facilities before the speech; participate in a luncheon after. Discuss w/ DD; Chip!

B

TO: KG 4/8
FROM: JM

Mr. Chip Kahn
May 28, 1986
Page 2

be able to join us, I need to know so that I can make arrangements for another speaker. He is very definitely our first choice.

Sincerely,

Mike/cmm
Michael A. Romansky

MAR/cmm
Enclosure

C

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July 3, 1986

DIRECT LINE
202/ 887-8069

Ms. Jodi Mathison
Personal Secretary
Office of Senator David Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510-2302

Dear Jodi:

I am herewith enclosing a copy of a press release issued by the Outpatient Ophthalmic Surgery Society to San Diego area newspapers. At this point, we expect about 500 in the audience, and hopefully, considerable media attention.

As I indicated during our conversation yesterday, I have spoken with the Senator's attorney and expect to hear shortly from Piraino. To reiterate, we would like to fit the following into the Senator's visit:

a. A breakfast or luncheon with the leadership of the Outpatient Ophthalmic Surgery Society, CooperVision (an ophthalmics manufacturer which is sponsoring the event), and perhaps the presidents of the Federated Ambulatory Surgery Association and the American Society of Outpatient Surgeons. During this gathering of about 12 people, we would hope to discuss certain outpatient surgery and physician reimbursement issues.

If used a further effort we'll do later

Doug should call Mike to see how utilized

b. Visits to two ambulatory surgical facilities, one ophthalmic and one non-ophthalmic office-based facility.

c. The Senator's speech, which is scheduled from 11:30 a.m. to 12:30 p.m.

d. If you wish, an autograph session in a prominent place on the exhibit floor. I would suggest that you or Piranha Press work this out directly with Karen Delaney, the Society's Executive Director, who can be reached at 619/692-4426.

If we were to start with a breakfast at 7:30 or 8:00, all activities would be concluded by 12:30, although that might be an excellent time for the Senator to be available near the spot where his book will be marketed. Alternatively, if the Senator wishes to start a little later, all activities should be concluded after the luncheon, around 2:00.

Please let me have your thoughts regarding these matters as quickly as possible so that we can make appropriate arrangements. Once again, thanks for all of your cooperation.

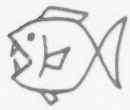
Sincerely,

Michael A. Romansky

MAR/cmm
Enclosure

E

PIRANHA



PRESS

Gary L. Diamond
Publisher

July 3, 1986

Mr. Mike Romansky
McDermott, Will & Emery
1850 K Street NW
Washington, DC 20006

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Romansky:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Outpatient Opthalmic Surgery Society Annual Meeting on July 19, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

F

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

G

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
July 19, 1986	11:30 a.m.	San Diego, CA	$5,000

H

OUTPATIENT OPHTHALMIC SURGERY SOCIETY
3960 Park Boulevard • Suite E • San Diego, California 92103 • (619) 692-4426

July 17, 1986

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Karen M. Delaney

Dear Doctor:

As a San Diego County ophthalmologist, you have a unique opportunity to attend the Annual Meeting of OOSS, one of the largest surgical specialty societies - without leaving town!

The 6th Annual Meeting of the Outpatient Ophthalmic Surgery Society begins next Thursday afternoon, July 17, at the Town & Country Hotel. You'll find a full educational program of interest to you as a clinician, as well as programs for your office manager/administrator and nurse/technician. In addition, you'll have the opportunity to see more than 140 exhibit booths with the latest equipment and supplies for outpatient ophthalmic surgery.

In addition to the regular program, we'll hear from Senator David Durenberger (R-MN) on Saturday at 11:30 AM. Sen. Durenberger will update us on the latest Medicare proposals which will affect all ophthalmologists. Just this past week H.C.F.A. has proposed a drastic reduction in professional fee reimbursement by Medicare; passage of this will have onerous implications. It is important that you are aware of all the proposed legislation affecting our specialty, and it is equally important that you lend your voice in support of our efforts.

OOSS has become one of the leading advocates for ophthalmic surgeons - don't miss this chance to participate and learn. We're offering a special registration fee for San Diego County offices: $180 for physicians and $130 for anyone in your office. Just come to the Registration Desk Thursday at 2:00, tell us you received this invitation, and register for the meeting. A program is enclosed which outlines all the sessions - and I think you'll see this is an opportunity not to be missed.

Sincerely,

KAREN M. DELANEY
Administrative Director

Enclosure

Experience . . .

OUTPATIENT OPHTHALMIC SURGERY SOCIETY

SAN DIEGO, CALIFORNIA
July 17 - 19, 1986

On Audiocassette

OUTPATIENT OPHTHALMIC SURGERY SOCIETY'S SIXTH ANNUAL MEETING was professionally recorded by **InfoMedix**. Audiotape copies of the presentations are now available by mail order.

****

PROGRAM No. S227

PHYSICIAN'S SESSION

THURSDAY, JULY 17, 1986

S227-1AB $20.00 (2 tapes) — **Ophthalmic Surgical Networking Seminar**, W. J. Collis, et al

FRIDAY, JULY 18, 1986

S227-2 $10.00 — **Radial Keratotomy**, R. Berkeley, et al

S227-3 $10.00 — **What's New in Intraocular Lens**, J. P. Gills, et al

S227-4 $10.00 — **How Free Cataract Surgery Affected My Practice, and What I Expect to Significantly Affect My Practice's Future**, J. L. Tennant, et al

S227-5 $10.00 — **Introduction of the 1986 Medical Guest of Honor, D. E. Williamson; Opinions Regarding the Future of Ophthalmology that I Would like to Share with Clinical Ophthalmic Surgeons**, A. E. Maumenee

S227-6 $10.00 — **Anesthesia (Local)/Ophthalmic**, D. B. Davis II, et al

S227-7 $10.00 — **Sterility Considerations in the Operating Room**, F. A. Richburg, et al

S227-8 $10.00 — **New Concepts in Surgical Techniques**, D. J. McIntyre, et al

S227-9 $10.00 — **Fraud & Abuse: Implications for the Ophthalmologist**, D. Millman, et al

SATURDAY, JULY 19, 1986

S227-10 $10.00 **Complications in Ocular Surgery -Panel Discussion,** R. Osher, et al

S227-11 $10.00 **Outpatient Ocular Surgery in a Hospital,** L. McMahan, et al

S227-12 $10.00 **Controlling Costs and Maintaining Quality,** D. McIntyre, et al

S227-13 $10.00 **Legislative and Regulatory Issues of Concern to the Ophthalmic Surgeon,** Senator D. Duranburger

S227-14 $10.00 **New Reimbursement Tips,** W. E. Rose Jr., et al

S227-15 $10.00 **Editorials,** H. Hirschman, et al

S227-16AB $20.00 (2 tapes) **Marketing,** J. R. Hirsch, et al

NURSES SESSION

FRIDAY, JULY 18, 1986

S227-18 $10.00 **Equipment and Staffing,** P. Emery

S227-19AB $20.00 (2 tapes) **Quality Assurance: Setting Protocols and Maintaining Them,** P. Schenck, J. Peters

SATURDAY, JULY 19, 1986

S227-20AB $20.00 (2 tapes) **Management Seminar,** A. F. Dean

S227-21 $10.00 **Budgeting/A.S.C.: The Nurse, Part I,** A. F. Dean

S227-22 $10.00 **Budgeting/A.S.C.: Part II,** A. F. Dean

S227-23 $10.00 **Stress Management,** I. Powell-Dubois

ADMINISTRATOR'S SESSION

FRIDAY, JULY 18, 1986

S224-24AB $20.00 (2 tapes) **The Business of Ophthalmology,** E. Kriss; **Marketing and Advertising: What Works and What's Different in Various Areas of the Country,** K. Camerota, et al

S227-25 $10.00 **Disposables: How Much are You Paying?,** R. Penrose, L. Santiago

SATURDAY, JULY 19, 1986

S227-26AB $10.00 **Surgicenter: A Multi-Special Approach,** H. E. Billig III, et al

S227-27 $10.00 **AAAHC Seminar**

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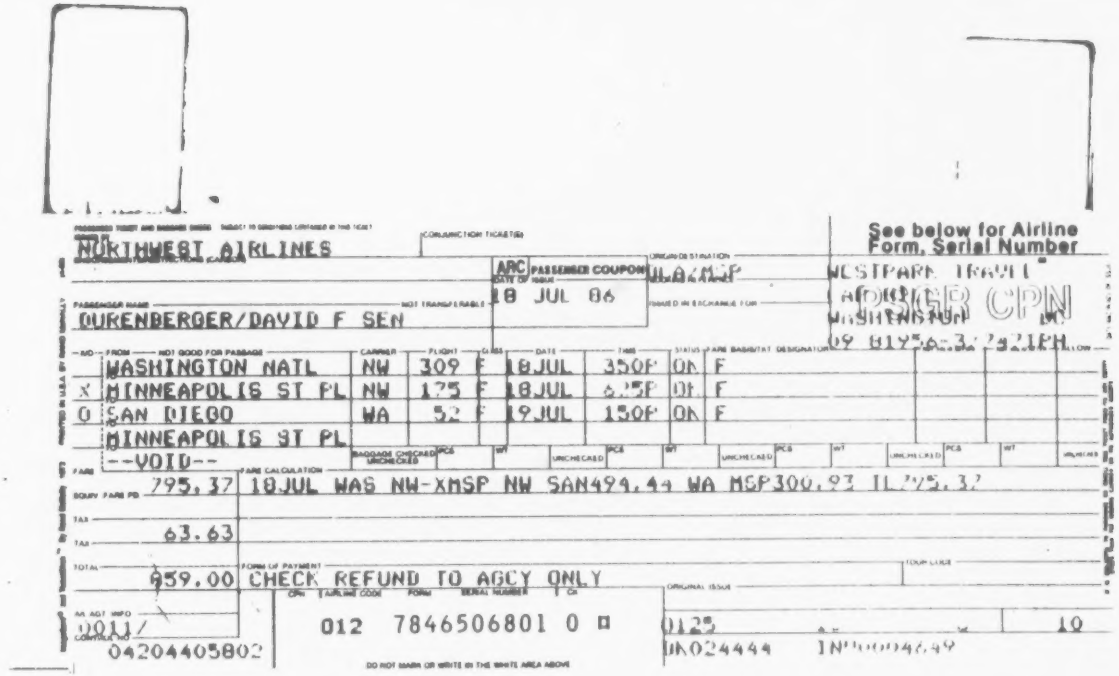

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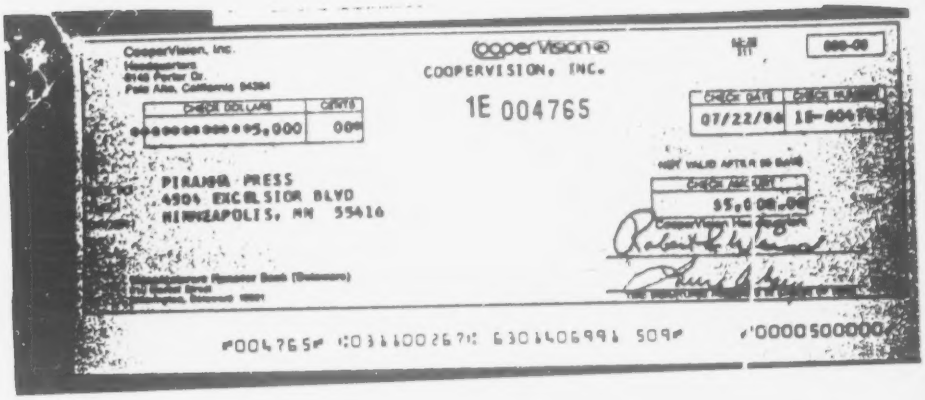
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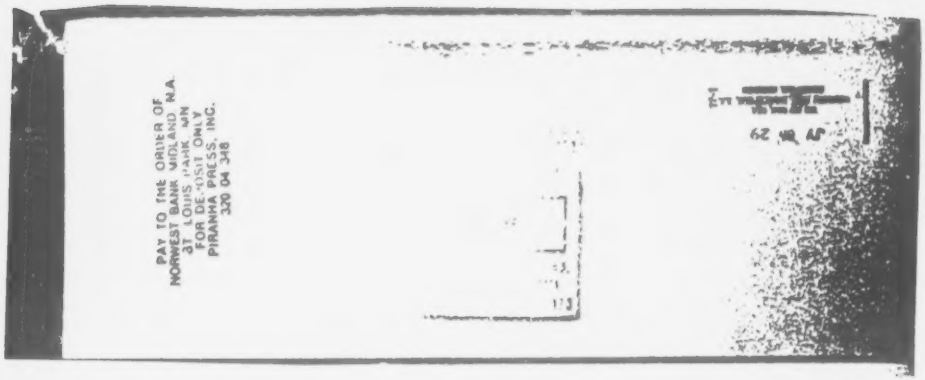
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*Not Admitted to District of Columbia

July 25, 1986

DIRECT LINE
202/
887-8069

PERSONAL & CONFIDENTIAL

The Honorable David Durenberger
147 Russell Senate Office Building
Washington, D.C. 20515

Dear Senator:

As always, it was a pleasure seeing you in San Diego this past weekend at the Sixth Annual Meeting of the Outpatient Ophthalmic Surgery Society. It goes without saying that your remarks were timely, stimulating, and encouraging, and your continued effort on behalf of quality eye care is greatly appreciated by OOSS' membership.

We appreciate your willingness to take an objective look at the issue of the appropriateness of requiring PRO review in advance of all cataract surgery, and understand that this provision has been deleted from the Senate Finance Committee package. We also hope that you will consider looking at a balanced and fair approach to the issue of cataract surgery reductions than what will be proposed by HCFA and has been included in the House Energy and Commerce Committee reconciliation package. It would appear that the approach embodied in the Senate Finance Committee bill, i.e. providing

HCFA with guidelines for the application of inherent reasonableness, coupled with some limitation on reductions in application to specific procedures, would strike such a balance between the various proposals under consideration. Indeed, I would hope that we might be able to discuss these important matters within the next couple of weeks when OOSS' leadership comes to Washington.

As I mentioned above, your remarks were extremely well received. Indeed, several members of OOSS asked whether it was appropriate to make contributions to your campaign in advance of the establishment of our organization's political action committee later this year. Accordingly, it is a privilege to enclose contributions from several of our members. I am also enclosing letters from Dr. McIntyre and Dr. Hessburg providing further elaboration of our support for your efforts.

Again, I hope that we will be able to get together within the next couple of weeks to discuss issues of concern to the ophthalmology and ambulatory surgery communities. We appreciate your continued willingness to listen, to learn, and to operate a YAG laser.

With best regards.

Sincerely yours,

Michael A. Romansky

MAR/cmm
Enclosures

R

PRE-APPOINTMENT INFORMATION

EVENT DATE: 3/18 Lunch — what DD sees in the future for nursing homes - long term care

TODAY'S DATE: 2/26

CONTACT: Bea Bleicher

TELEPHONE: 452-0770

APPOINTMENT WITH: (DD) STAFF

FOR: luncheon (speech) ~12.00

TITLE: University Club 16th St. NW

COMPANY: OWENS ILLINOIS (10/15 min drive)

ISSUE: long term care & corp attitudes - (HEALTH)

NUMBER OF PEOPLE: 10-15

ADDITIONAL NAMES:

Owens Illinois is a packaging co that has since gotten into nursing home chains.

* Chairman of the board
* president
* top officers

NOTES: $2K + transportation to downtown DC

Pro supporter

OK (P.P.)

* sending letter by messenger (2/26)

SPECIAL COUNSEL HEARING EX. 179

A

OWENS-ILLINOIS

Beatrice K. Bleicher
Washington Counsel
and Director of Federal
Government Relations

Chip Dole
David D.

February 26, 1986

The Honorable David F. Durenberger
United States Senate
375 Russell Senate Office Building
Washington, D. C. 20515

Dear Senator Durenberger:

Owens-Illinois would be honored to have you join us on March 18 at 12:00 p.m. for lunch and a discussion of long-term health care policy trends from your perspective as Chairman of the Senate Finance Committee Subcommittee on Health. The luncheon will be held at the University Club, 1135 Sixteenth Street, N. W., in the Presidents' Room.

Owens-Illinois' Chairman Robert J. Lanigan, our President, and top executives involved in health care operations are coming to Washington to spend the day with policymakers and analysts discussing long-term health care issues. We are especially interested in your view of future Congressional action with respect to nursing home accessibility and quality-of-care issues. We would also like to know what you see as the key issues facing private sector providers of nursing home care.

Although you are more familiar with Owens-Illinois as a diversified packaging manufacturer, we have recently become the nation's sixth largest operator of nursing homes through a wholly-owned subsidiary Health Care and Retirement Corporation (HCR). HCR also develops and renovated nursing homes. I have enclosed a copy of our 1984 Annual Report although the information on page 18-19 on our health care operations is now somewhat out-dated. With recent acquisitions the company, through its wholly-owned subsidiary Health Care and Retirement Corporation (HCR) based in Lima, Ohio, currently has a total of 86 nursing home facilities

in 16 states. As the attached list indicates, a large number of those homes are located in Ohio. Also enclosed is the initial list of Owens-Illinois participants at the meeting. I expect that some additional HCR operating people will attend as well.

Other speakers during the day include Congressman Stark, Senator Glenn, representatives of the American Health Care Association, Richard Merritt of the Intergovernmental Health Policy Project at George Washington University, and Jack Meyer from the American Enterprise Institute.

We hope you will be able to fit this luncheon meeting into your busy schedule. Please let me know if you have any questions. We look forward to an early response.

Very truly yours,

Beatrice K. Bleicher

BKB/cas

Enclosures

C

March 18, 1986

University Club
1135 Sixteenth Street, N. W.
(202) 862-8800

8:00 a.m.
Presidents' Room

Breakfast meeting - View from The House of Representatives

Guest

Representative Fortney H. (Pete) Stark (D-CA)
Chairman, Subcommittee on Health
House Ways and Means Committee

10:00 a.m.
Meeting Room E

State Legislative Trends

Guest

Richard Merritt, Director
Intergovernmental Health Policy Project

11:00 a.m.
Meeting Room E

Reagan Administration Regulatory Initiatives

Guest

Bartlett Fleming, Deputy Director (Acting)
Health Care Financing Administration
Department of Health and Human Services

12:00 p.m.
Presidents' Room

Lunch Meeting - View from the Senate

Guest

Senator David F. Durenberger (R-MN)
Chairman, Subcommittee on Health
Senate Finance Committee

D

31-403 O—90——12

2:00 p.m.
Meeting
Room E

Demographics and Federal Long-term Care Policies

Guest

Jack Meyer, Director
Center for Health Policy Research
American Enterprise Institute

3:00 p.m.
Meeting
Room E

Wrap-up

3:30 p.m.

Adjournment

E

Form 518-R19

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Explanation and any special instructions

Honorarium to Sen. David Durenberger (IR-Minnesota) to speak at Health Care Presentation to Owens-Illinois executives on March 18, 1986

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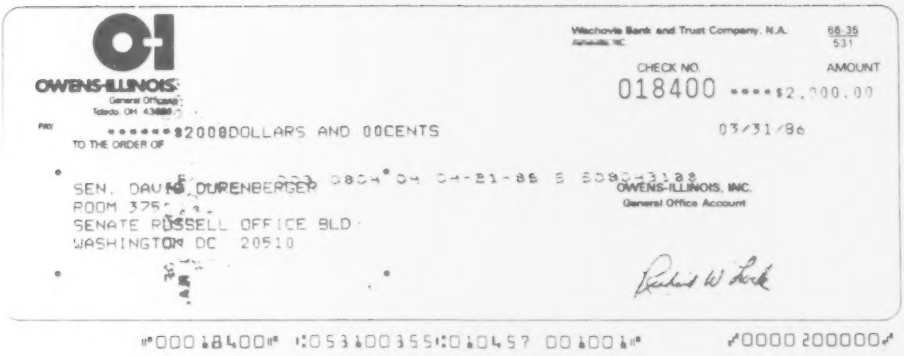
		Drawee Bank	Check No. & Date
		Vendor No. | Month Charged | Invoice No. | Price OK	



OWENS-ILLINOIS
General Offices
Toledo, OH 43666

Wachovia Bank and Trust Company, N.A.
Asheville, NC

66-35
531

CHECK NO. 018400

AMOUNT ****$2,000.00

PAY ******$2000DOLLARS AND 00CENTS

03/31/86

TO THE ORDER OF

SEN. DAVID DURENBERGER
ROOM 375
SENATE RUSSELL OFFICE BLD
WASHINGTON DC 20510

OWENS-ILLINOIS, INC.
General Office Account

Richard W Lock

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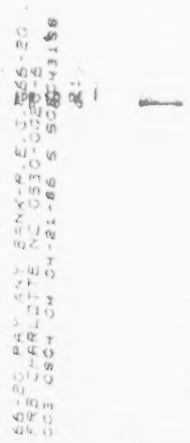
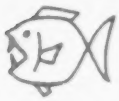
Pay to Piranha Press
San Luis Lunatics

PAY TO THE ORDER OF
NORBERT-SMITH MEDICINE CO. [illegible]
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS NO.
320 06 346



PIRANHA



PRESS

Gary L. Diamond
Publisher

1/28/77

Attn: Accounts Payable Dept.

Piranha Press, a Minnesota Corporation, has a contract to handle Sen. Durenbergers book publications (which includes speaking engagements, etc.) and that income goes to Piranha Press rather then to the Senator. I have entered our identification # on the W-9 form.

Gary Diamond/publisher

4504 EXCELSIOR BLVD. - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

I

VOLUME VIII

EXHIBITS 180–202

PALO ALTO MEDICAL FOUNDATION
HEALTH CARE • RESEARCH • EDUCATION

February 20, 1985

OFFICE OF THE PRESIDENT

Senator David F. Durenberger
United States Senator, Minnesota
Russell Senate Building
SR-375
Washington, DC 20510

Dear Senator Durenberger:

We are pleased with the response to our Symposium, "Entrepreneurial Strategies for the Medical Profession" to be held April 12th and 13th in San Francisco at the St. Francis Hotel.

Enclosed is a hotel registration card for the St. Francis. As stated in our letter to you of January 4th, we will be glad to cover your room charges for a Standard Room on our master coverage; however, please check your bill and pay for all incidentals before you depart.

The Hotel has agreed to upgrade all Speakers at the Standard Room price to the best available at the time of the Symposium, so we feel you will be pleased with your accommodations. Be sure to mark that you are a Speaker and check the Standard Room rate when you return the form.

We appreciate the important part that you are playing in this Symposium, and we look forward to seeing you soon. If you have any questions, please do not hesitate to contact me.

Sincerely,

Nancy W. Collins
Assistant to the President

NWC:mg

Enclosure

P.S.

Please return card to St. Francis as soon as possible.

PS - Hope Mrs Durenberger can accompany you - it's our pleasure to pay for your double!

SPECIAL
COUNSEL
HEARING
EX. 180

A

President and Chief Executive Officer, ROBERT W. JAMPLIS, M.D., BOARD OF TRUSTEES, Chairman of the Board, ELMER H. DOHRMANN, First Vice-Chairman, ANTHONY P. MEIER, Second Vice-Chairman, R. HEWLETT LEE, M.D., Secretary, DAVID DRUKER, M.D., Treasurer, MAURICE FOX, M.D., JOHN A. DITZ, LEONARD W. ELY, ROBERT J. GLASER, M.D., ROBERT M. HAYNIE, SYDNEY P. HECKER, M.D., CLARENCE E. HELLER, OAKLEY HEWITT, M.D., H. T. HILLIARD, ROBERT W. JAMPLIS, M.D., GEORGE P. JANETOS, M.D., RYLAND KELLEY, M. RICHARD MASER, M.D., MRS. WILLIAM W. MEIN, JR.

400 Channing Avenue, Palo Alto, CA 94301, (415) 321-4121

9/84

PALO ALTO MEDICAL FOUNDATION

HEALTH CARE • RESEARCH • EDUCATION

Sample

OFFICE OF THE PRESIDENT

March 22, 1985

Senator David F. Durenberger
United States Senator, Minnesota
Russell Senate Building
SR-375
Washington, DC 20510

Dear Sen. Durenberger:

We now have over 300 participants registered from throughout the United States for our Symposium, "Entrepreneurial Strategies for the Medical Profession," to be held on April 12 and 13 in San Francisco at the St. Francis Hotel. And with three weeks remaining, we anticipate additional registrations.

We would appreciate receiving as soon as possible a list of any audio visual equipment that you may need to emphasize certain points during your speech. Also, please send us a full set of all materials that you would like reproduced and handed out in the registration packet. If we do not receive your materials by April 5th, we will presume that you either do not wish to hand out any or that you will distribute them yourself during your session.

I am enclosing several extra brochures in case you have any suggestions for additional people to invite to our Symposium. We are anxious to make this a profitable conference as well as have a full attendance, and thus we would appreciate your giving the brochures to someone whom you think would be interested in attending.

We are pleased with the interest expressed in this Symposium, and anticipate a very informative and enjoyable conference. We greatly appreciate your participation, and please let me know if we can be helpful in any way prior to the Symposium.

Sincerely,

Nancy W. Collins
Assistant to the President

NWC:mg

President and Chief Executive Officer, ROBERT W. JAMPLIS, M.D., BOARD OF TRUSTEES Chairman of the Board, ELMER H. DOHRMANN, First Vice-Chairman, ANTHONY P. MEIER, Second Vice-Chairman, R. HEWLETT LEE, M.D., Secretary, DAVID DRUKER, M.D., Treasurer, MAURICE FOX, M.D., JOHN A. DITZ, LEONARD W. ELY, ROBERT J. GLASER, M.D., ROBERT M. HAYNIE, SYDNEY P. HECKER, M.D., CLARENCE E. HELLER, OAKLEY HEWITT, M.D., H.T. HILLIARD, ROBERT W. JAMPLIS, M.D., GEORGE P. JANETOS, M.D., RYLAND KELLEY, M. RICHARD MASER, M.D., MRS. WILLIAM W. MEIN, JR.

400 Channing Avenue, Palo Alto, CA 94301, (415) 321-4121

9/84

B

PIRANHA

PRESS

Gary L. Diamond
Publisher

April 4, 1985

Ms. Nancy W. Collins
Palo Alto Medical Foundation
300 Homer Avenue
Palo Alto, CA 94301

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Ms. Collins:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before your organization in the near future.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book, Neither Madmen Nor Messiahs, and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book. It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

Because Senator Durenberger's appearance before your organization will be in promotion of Neither Madmen Nor Messiahs, we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

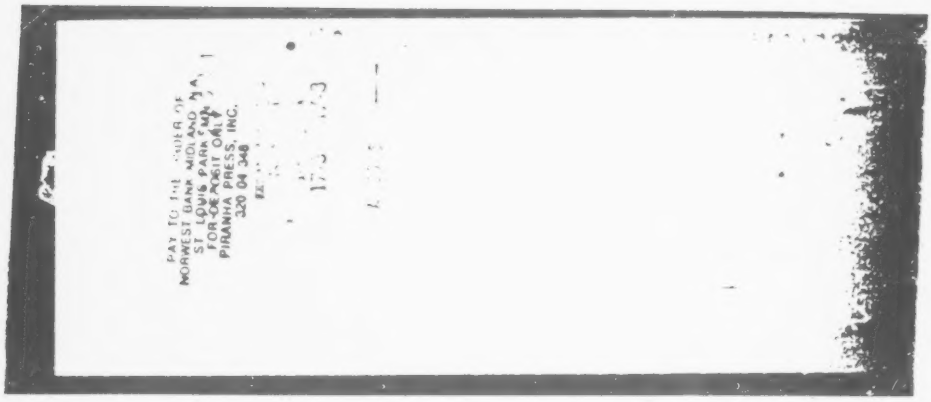
D

APPEARANCE SCHEDULE

Date	Place	Amount
April 13, 1985	San Francisco, CA	$2,000

E

PALO ALTO MEDICAL FOUNDATION
HEALTH CARE DIVISION
WELLS FARGO BANK
PALO ALTO MEDICAL FOUNDATION
HEALTH CARE DIVISION
William C. Brown


PAY TO THE ORDER OF
NORWEST BANK MIDLAND NA
ST LOUIS PARK BRANCH
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PIRANHA PRESS, INC.
320 04 348

Sample

PALO ALTO MEDICAL FOUNDATION

HEALTH CARE • RESEARCH • EDUCATION

OFFICE OF THE PRESIDENT

April 12, 1985

Senator David F. Durenberger
United States Senator, Minnesota
Russell Senate Building
SR-375
Washington, D. C. 20510

Dear Senator Durenberger:

We are very pleased that we have over 400 registered for our symposium, "Entrepreneurial Strategies for the Medical Profession," to be held in San Francisco on April 12 and 13, 1985. We are most appreciative of your participation.

Enclosed is a check for $2,110 (made payable to Piranaha Press) which includes your honorarium ($2,000), meals while at the symposium (Friday and Saturday breakfasts @ $10 and Friday dinner @ $40), and $50 for ground transportation to and from the airport. Your airfare has been charged to our account

As stated in our letter of January 4, we will pay for your hotel room on our master account. However, please verify your bill and pay for all incidential charges before you depart.

While you are at the symposium, please let our staff know if there is anything we can do for you.

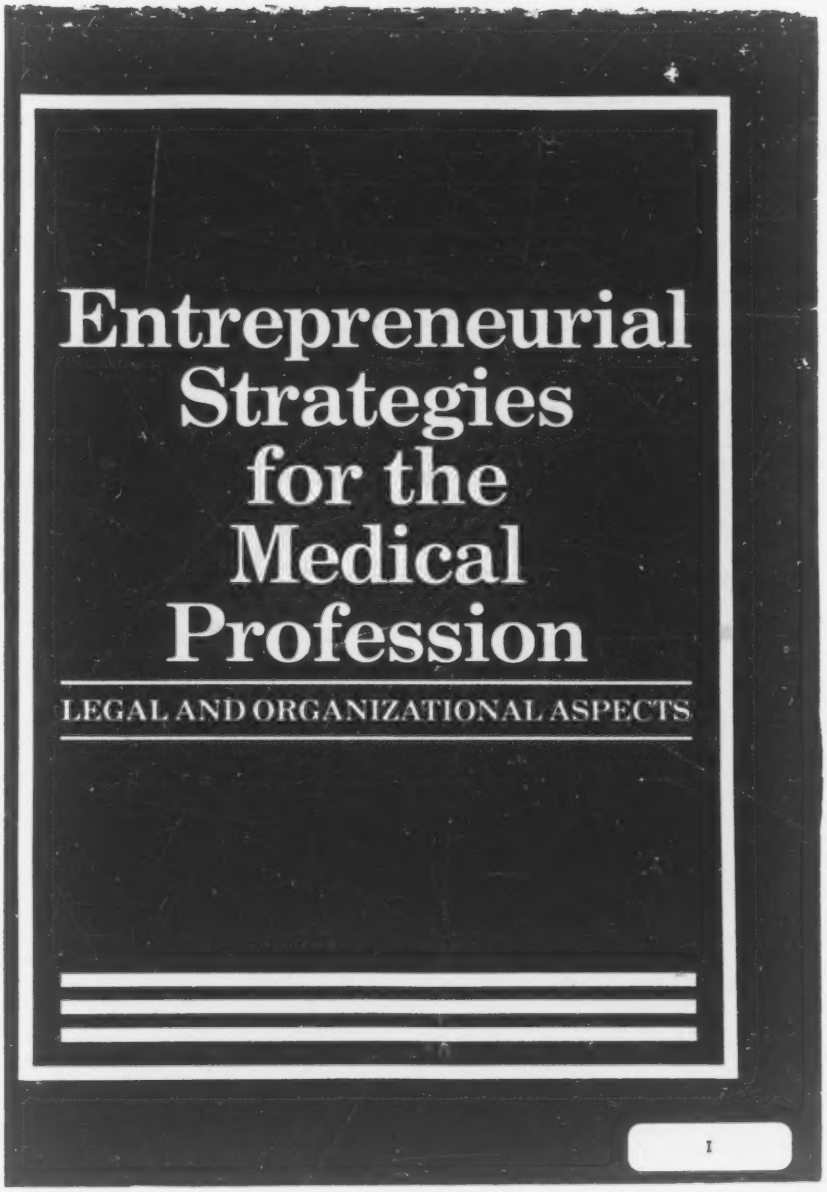
Sincerely,

Nancy W. Collins
Assistant to the President

President and Chief Executive Officer, ROBERT W. JAMPLIS, M.D. BOARD OF TRUSTEES Chairman of the Board, ELMER H. DOHRMANN, First Vice-Chairman, ANTHONY P. MEIER, Second Vice-Chairman, R. HEWLETT LEE, M.D., Secretary, DAVID DRUKER, M.D., Treasurer, MAURICE FOX, M.D., JOHN A. DITZ, LEONARD W. ELY, ROBERT J. GLASER, M.D., ROBERT M. HAYNIE, SYDNEY P. HECKER, M.D., CLARENCE E. HELLER, OAKLEY HEWITT, M.D., H. T. HILLIARD, ROBERT W. JAMPLIS, M.D., GEORGE P. JANETOS, M.D., RYLAND KELLEY, M. RICHARD MASER, M.D., MRS. WILLIAM W. MEIN, JR.

400 Channing Avenue, Palo Alto, CA 94301, (415) 321-4121

H


Entrepreneurial Strategies for the Medical Profession
LEGAL AND ORGANIZATIONAL ASPECTS
I

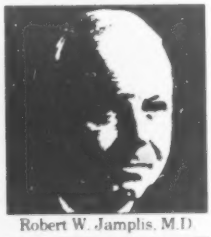
The Faculty

Speakers

David F. Durenberger, J.D.

Charles C. Edwards, M.D.

Paul M. Ellwood, Jr., M.D.


Robert W. Jamplis, M.D.

Albert R. Jonsen, Ph.D.

Robert H. Rosenfield, L.L.B.

Leonard Silk, Ph.D.

Walter L. Weisman, L.L.D.

The Hon. David F. Durenberger, J.D.
United States Senator, Minnesota; Committee for Finance, and Chairman, Subcommittee on Health.

Charles C. Edwards, M.D.
Pres. & CEO, Scripps Clinic and Research Foundation; Former Asst. Secretary for Health (HEW).

Paul M. Ellwood, Jr., M.D.
Pres., InterStudy; Clinical Prof. of Neurology, Pediatrics and Physical Medicine, Univ. of Minn.

Robert W. Jamplis, M.D.
Pres. & CEO, Palo Alto Medical Foundation; Institute of Medicine, National Academy of Sciences; Board of Regents, American College of Physician Exec.

Albert R. Jonsen, Ph.D.
Prof. of Ethics in Medicine, Univ. of Calif. at Berkeley; Former Pres., Univ. of San Francisco.

Robert H. Rosenfield, L.L.B.
Atty. & Exec. Comm., Memel, Jacobs, Pierno & Gersh; Consultant, Joint Comm. on Accreditation of Hospitals' Multihospital Systems Project.

Leonard Silk, Ph.D.
Economics Columnist, New York Times; Author and Former Senior Fellow, Brookings Institution.

Walter L. Weisman, L.L.D.
Pres. & COO, Amer. Medical Intl., Inc.; Exec. Comm., Stanford Law School Board of Visitors.

Panelists

Betty Jane Anderson, J.D.
Neil L. Chayet, J.D.
L. Barry Costilo, J.D.
David G. Fearheller, M.B.A.
William A. Flexner, Dr.P.H.
Charles H. Harrison, M.B.A.
Raymond E. Hughes, M.B.A.
George P. Janetos, M.D., F.A.C.R.
Sherwin L. Memel, J.D.
Glen D. Nelson, M.D.
Martin J. Thompson, J.D.
Edwin C. Whitehead, D.Sc. (Hon.)
David G. Williamson, Jr., M.H.A.

The Symposium

Sponsored by the
Palo Alto Medical Foundation
San Francisco•April 12-13, 1985

Purpose

To enable physicians, lawyers, accountants and medical administrators to respond more effectively to the rapidly changing social, economic, legal and organizational environment facing the practice of medicine and the delivery of health care.

Plan

Since these diverse groups share more common problems than they do assumptions and approaches, they will increasingly need to find ways to work together. The conference is specifically designed to provide opportunities to hear the views of experts, as well as each others', and to engage in frank dialogue. The "how to" interaction workshops will also be an important part of our format. We plan not only to pose more questions, but to give answers to what lies ahead.

Background

Ten years ago, health care was aptly characterized as a "cottage industry" although it was consuming nearly a tenth of the nation's economic resources. The recent changes have outmoded that description; the delivery of quality care increasingly demands capital that cannot possibly be provided by patient fees alone. How to survive in this new world of big business is the central theme of the conference.

The Challenge

The challenge facing the conference participants is to learn how to handle these changes without diluting the quality of medical care and the humanity with which they are provided. Thousands of physicians and other key health care professionals are at the crossroads in making new and fundamental decisions. Yet substantial hurdles are imposed by laws which have not caught up with the transformation of medicine nor by patterns of payment which often discourage entrepreneurial efficiency.

Conference Host

This national symposium is being sponsored by the Palo Alto Medical Foundation, one of the country's leading centers for medicine. The Foundation's three divisions are Health Care (the Palo Alto Medical Clinic), Research and Education. The Health Care Division, established 54 years, ago, has a medical staff of 145 physicians practicing in over 50 areas of medicine. Fourteen research scientists and a strong complement of research fellows carry on advanced medical research, which has earned for the Research Institute wide national and international recognition. The Education Division was created to carry on significant national programs in professional and public education in medicine and health maintenance.

Entrepreneuri

FRIDAY, APRIL 12

8:30-9:00 a.m.	Registration
9:00-9:05	"Welcome" Robert W. Jamplis, M.D.
9:05-9:45	"Entrepreneurial and Organizational Trends in Medicine Today" Paul M. Ellwood Jr., M.D.
9:45-10:30	"Capital Formation and Other Financial Strategies in the Non-Profit Sector" Charles C. Edwards, M.D.
10:30-11:00	Coffee Break
11:00-11:45	"Diversification in the For-Profit Hospital Sector" Walter L. Weisman, L.L.D.
11:45-12:30 p.m.	"Legal Pitfalls in Organizing the Delivery of Medical Care to Meet the Demands of the Present: Can We Do What We'd Like to Do?" Robert H. Rosenfield, L.L.B.
12:30-1:45	Luncheon "The Future of Health Care in These Uncertain Economic Times" Luncheon Speaker: Leonard Silk, Ph.D.

WORKSHOPS (Select two)

2:00-3:30 3:45-5:15	1. "Anti-Trust Risks in the Health Care Field" Panelists: Ned L. Chayet, J.D. (Moderator), L. Barry Costilo, J.D., Martin J. Thompson, J.D.

Workshop Description

Anti-Trust Risks in the Health Care Field

New organizational strategies in the delivery of health care often raise anti-trust issues from the perspective of both the health care provider and the enforcement agency.

HMO/PPO Formation

This workshop will focus on technical issues surrounding the development of prepaid and preferred provider health plans. Participants will discuss ways to measure and manage risk, regulatory and anti-trust considerations, and the professional liability issues facing providers who contract with non-traditional health care plans.

Evaluating and Structuring Joint Ventures, Mergers, and Other Options

The panelists will consider the legal entities used by two organizations to pursue a common project. Particular areas of discussion include alternate approaches based on tax, liability, strategic/operational implication, certificate of need, and other legal, managerial, and economic considerations.

Physicians Accessing the Capital Markets

The capital markets have been foreign to physicians, but recently a new breed of entrepreneurial doctors has appeared on the scene. In the workshop we will discuss the interests of venture capitalists, individual entrepreneurs, investors, and groups of physicians in these strategies.

ial Strategies

	WORKSHOPS (Continued)
Workshops 2:00 - 3:30 p.m. Break Workshops 3:45 - 5:15	2. "HMO/PPO Formation" Panelists: Glen D. Nelson, M.D. (Moderator), Betty Jane Anderson, J.D., Raymond E. Hughes, M.B.A.
	3. "Evaluating and Structuring Joint Ventures, Mergers, and Other Options" Panelists: Sherwin L. Memel, J.D. (Moderator), William A. Flexner, Dr.P.H., David G. Williamson, M.H.A.
	4. "Physicians Accessing the Capital Markets" Panelists: George P. Janetos, M.D., F.A.C.R. (Moderator), David G. Fearheller, M.B.A., Charles H. Harrison, M.B.A., Edwin C. Whitehead, D. Sc. (Hon.).
5:15	Adjournment (Dinner on your own)

SATURDAY, APRIL 13

9:00-9:45 a.m.	"Quality and Humanism: What About the Patient?" Albert R. Jonsen, Ph.D.
9:45-10:30	"Current Legislation: What Is Congress Apt to Do?" Senator David F. Durenberger, J.D.
10:30-11:00	Coffee Break
11:00-12:00	"The Bottom Line: Where Will These Strategies Take Medicine?" Panelists: Robert W. Jamplis, M.D. (Moderator), David F. Durenberger, J.D., Charles C. Edwards, M.D., Paul M. Ellwood, Jr., M.D., Albert R. Jonsen, Ph.D. Robert H. Rosenfield, L.L.B., and Walter L. Weisman, L.L.D.
12:00 noon	Closing

Panelists

Betty Jane Anderson, J.D.
Associate General Counsel & Director of Medical and Legal Affairs, American Medical Association.

Neil L. Chayet, J.D.
Counsel, Gaston Snow & Ely Bartlett; CBS Daily National Syndicated Radio Program.

L. Barry Costilo, J.D.
Senior Trial Attorney, Federal Trade Commission's Bureau of Competition's Health Care Office.

David G. Fearheller, M.B.A.
Sr. Vice Pres. and Managing Director, Health Care Finance Group, Dean Witter Reynolds, Inc.

William A. Flexner, Dr.P.H.
Pres., Flexner & Associates, Inc.; Editorial Board, Journal of Health Care Marketing.

Charles H. Harrison, M.B.A.
Partner, Arthur Anderson & Co.; Specialist, Health Care Practice.

Raymond E. Hughes, M.B.A.
Vice President and Director, Business and Marketing, Scripps Clinic and Research Foundation.

George P. Janetos, M.D., F.A.C.R.
Board of Trustees, Palo Alto Medical Foundation; Past Pres., American Group Practice Association.

Sherwin L. Memel, J.D.
Atty. & Sr. Partner, Memel, Jacobs, Pierno & Gersh; Past Pres., Calif. Soc. for Healthcare Attys.

Glen D. Nelson, M.D.
President, Park Nicollet Medical Center; Chairman, American MedCenters, Inc.

Martin J. Thompson, J.D.
Partner, Memel, Jacobs, Pierno & Gersh; Author, Anti-Trust and the Health Care Provider.

Edwin C. Whitehead, D.Sc. (Hon.)
Pres., Whitehead Associates; Founder Technicon, Inc., and Whitehead Institute at M.I.T.

David G. Williamson, Jr., M.H.A.
Exec. Vice Pres., Domestic Development, Hospital Corporation of America.

Helpful Facts

How To Be a Symposium Participant

For your convenience, you will find a simple registration form on the opposite page. Because of the particular significance of the symposium and the popularity of San Francisco in springtime, an early return of your registration is advised (early registration assures first choice of the popular workshop sessions). Attendance will be limited.

A special Friday program (optional) for your spouse or guests is being planned jointly by the Palo Alto Medical Foundation and the San Francisco Convention & Visitors Bureau. This program will include a San Francisco city tour, lunch and special shopping.

To accommodate any special needs you may have, please telephone:

Nancy W. Collins
Conference Manager
Palo Alto Medical Foundation
(415) 321-4121, extension 2676
1-800-325-3236 (except CA)

Where and When

The Symposium begins Friday morning, April 12, 1985, and ends at noon on Saturday, April 13, affording a memorable weekend opportunity to enjoy San Francisco at its springtime finest (special Symposium room rates can be stretched through the weekend). Participants may register Thursday evening, and the advance registration booth will be open from 5:30 to 7:30 p.m. (Mezzanine)

Your Hotel

The Westin St. Francis Hotel is one of San Francisco's premier hotels and meeting places, facing the city's center at famed Union Square. When you return your reservation form to us, please indicate if you want hotel information. You will then be sent a card specifying you are a Symposium participant which you can mail to the St. Francis Hotel indicating your accommodation needs.

Special courtesy room rates for this meeting:
Singles: $89, $110, $135.
Doubles: $100, $120, $155.

San Francisco Highlights

Examples of the city's fine entertainment:

- San Francisco Symphony
- San Francisco Ballet
- American Conservatory Theater
- Museum of Modern Art
- Palace of Fine Arts
- California Academy of Science and Golden Gate Park
- Nearby sight-seeing: the Redwoods, the Wine Country, Carmel and Montery Bay, Stanford University, Santa Cruz Beaches.

Registration

ENTREPRENEURIAL STRATEGIES FOR THE MEDICAL PROFESSION

Legal and Organizational Aspects
April 12-13, 1985

The Palo Alto Medical Clinic, as an institution accredited by the ACCME, certifies that this Symposium is accredited hour-for-hour for 11 hours of Category 1 credit.

Please enroll me as a participant in your two-day San Francisco Symposium. Enclosed is my check for $245 which includes registration and symposium materials, coffee breaks, and lunch on Friday. Registrations are accepted on a first-come, first-serve basis, and early registration is strongly advised. Refunds, less a $25.00 service charge, will be granted to cancellations prior to April 1, 1985.

Name (please print) _____

Affiliation _____ Specialty _____

Mailing Address _____

City _____ State _____ Zip _____ Phone _____

Please number from 1 to 4, in order of priority, your choices for the Friday afternoon workshops. You will be assigned to two workshops on a first-come basis.

☐ 1. "Anti-Trust Risks in the Health Care Field"

☐ 2. "HMO-PPO Formation"

☐ 3. "Evaluating and Structuring Joint Ventures, Mergers, and Other Options"

☐ 4. "Physicians Accessing the Capital Markets"

Indicate below if applicable:

☐ Please rush hotel information.

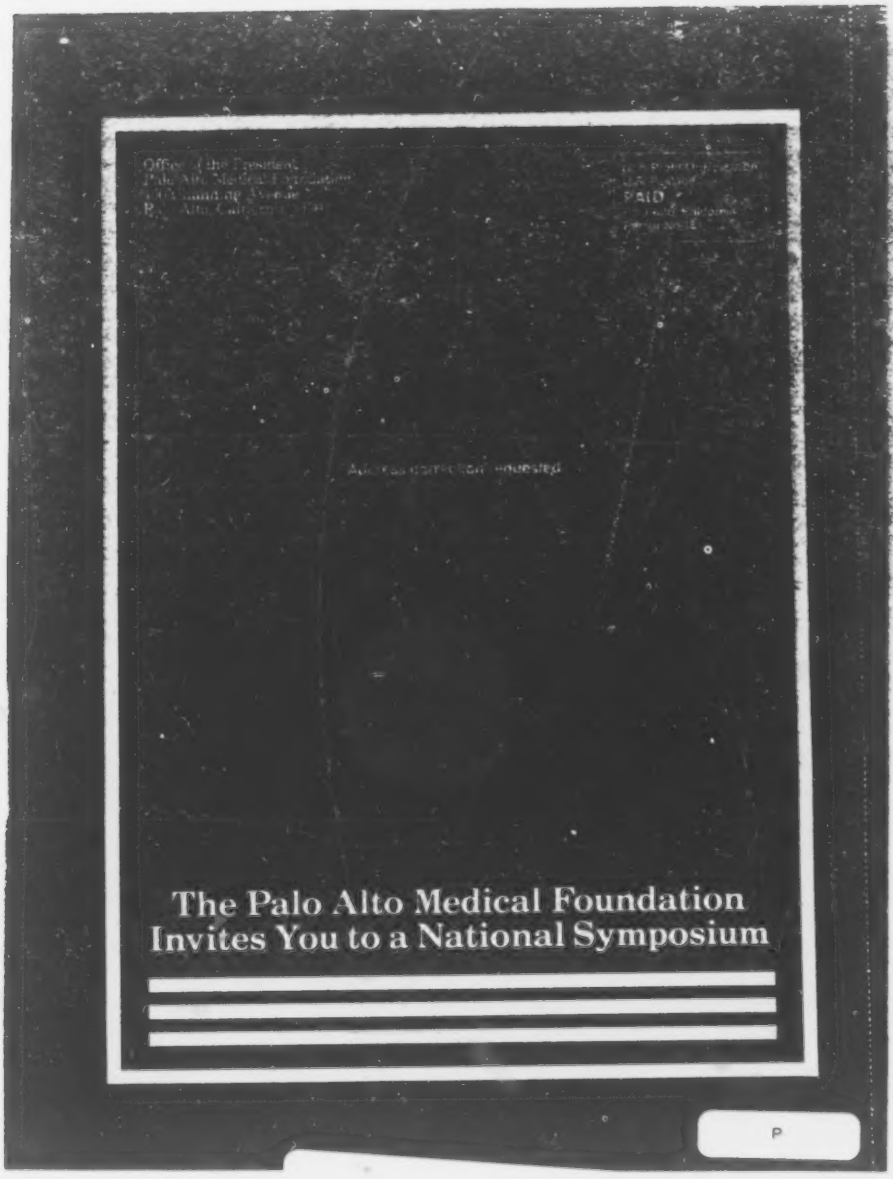
☐ I will bring my spouse/guest(s) to lunch Friday (there is an additional $25.00 charge). If yes, give name(s): _____

Check is enclosed for ____ guest(s).

☐ I would like information on the Friday program for spouse/guest(s).

Please mail this form and a check for $245 (plus any cost for Friday lunch guest) made payable to the Palo Alto Medical Foundation to the address below. Your registration will be promptly confirmed by mail.

Nancy W. Collins, Conference Manager, Palo Alto Medical Foundation
400 Channing Avenue, Palo Alto, California 94301


PAID
The Palo Alto Medical Foundation
Invites You to a National Symposium

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FROM J-[illegible]/ED

SCHEDULING INFORMATION

SPEECH 12/5/86 12 00 noon
TYPE OF EVENT EVENT DATE/TIME

Podiatry Practice Association
GROUP NAME

~200
~5K

Contact: David yates / Karen Doyne
Phone 202-659-0330
Key People _____
_____
_____
_____
_____

Topic Re: clinical lab fees/DRG's for hospital based physicians

LOCATION OF EVENT San Francisco, CA
Place Ramada Renaissance Hotel
Room _____
Phone Number _____
Directions _____

FOLLOW-UP
Thanks Sent _____ _____
(date)
Photo _____ Sent _____
(y/n) (date)
Photo to Media _____
(date)
Membership Lists
Received _____
(y/n)
Computerized _____
(y/n)
Filed _____
(y/n)
Regret Sent _____
Greeting Sent _____
(y/n)

STAFFING
Briefing Memo _____
Photo _____
Speech _____

MISCELLANEOUS

SPECIAL
COUNSEL
HEARING
EX. 181

A

8/26/86
REQUEST DATE

FROM JJD/DC

thology Practice Association

1225 Connecticut Ave., N.W.
Suite 303
Washington, D.C. 20036
(202) 659-0330

August 26, 1986

The Hon. David Durenberger
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

As you know, the prospective payment system and other reforms in government health care financing are changing the face of the nation's health care system. We would very much enjoy hearing your views and insights -- as an author and a chief congressional architect of these reforms -- at the annual meeting of the Pathology Practice Association, being held this year on Dec. 2-5 in San Francisco, California.

We invite you to be our luncheon speaker at noon on Friday, Dec. 5, at the Ramada Renaissance Hotel in San Francisco. We would be pleased to make arrangements for honorarium, first-class travel and lodgings.

The meeting is being sponsored jointly by the Pathology Practice Association (a nationwide organization) and the California Society of Pathologists. As hospital-based physicians covered by both Medicare Part A and Part B, pathologists have particular concerns regarding health care financing, such as reimbursement for clinical lab fees and the prospect of DRGs for hospital-based physicians. Your views on such issues, and on health care reform in general, would be welcome.

When you know whether this event will fit into your schedule, or if you need further information in the meantime, please contact Paul Johnson in Washington at 659-0330. I hope you can join us. I am certain our membership would find your remarks interesting and useful.

Sincerely,

David Yates, M.D.

cc: Doug Kelley

B

MEMORANDUM

Senator - if you're in late tomorrow night could we take a few minutes to touch base on scheduling?

TO: Senator

FROM: Jodi

DATE: September 30, 1986

RE: December Scheduling Requests

COPIES TO: Doug Kelley

ACTION: F.Y.I. but I also [redacted] to have a scheduling meeting before you leave to make decisions on these and others.

[redacted] I need to fill you in on a couple of scheduling requests for December. Paul will be mentioning a possible A.G.E. meeting with Don Kennedy of Sanford. Don would like to schedule something at Sanford, or nearby, sometime before the end of this year.

I bring this up because when Paul approached me regarding Don Kennedy and a possible date I told him that you did have two speech requests in the San Fransisco area for Dec. 5th and if you were interested we could do all this in one trip.

The two speech requests are:

1. Remarks to the Pathology Practice Association in San Francisco (this is the group Karen Doyne represents)

Date: 12/5/86 **Time:** 12:00 noon
$$: 5K **Group Size:** 200
Re: clinical lab fees/DRG's for hospital based physicians

2. Remarks to the Hospital Corporation of California in Monterey, Ca

Date: 12/5/86 **Time:** 12:00 noon
$$: 5K **Group Size:** 200
Re: what DD sees happening in federal health care policy

Monterey is approximately 2 hours driving time from San Francisco. It's 35 minutes by air and there are flights leaving every hour (four flights leave between 12:00noon and 1:00pm).
[redacted]

I was just given the information that you will be in Boston on the evening of Dec. 1 and the morning of the 2nd.
I've also been in contact with Tim Conlan about the rural conference in Minnesota during this time period. He told me they were aiming for sometime between Dec. 2-4, but they only need a day and a half.

C

If the decision is to go with this, your schedule would look like this:

Dec 1: Evening in Boston
Dec 2: Morning in Boston/Afternoon to Minneapolis
Dec 3-4: Minneapolis - rural conference
Dec 4: Evening - fly to San Francisco
Dec 5: **(FRIDAY)** Schedule above events - my recommendation is to put the A.G.E. event on as a breakfast, schedule the pathologists in late morning, and schedule the Hospital Corporation of CA (Monterey) for early afternoon.
Dec 6/7: Possible days off in Monterey (the HCC conference is at a convention center right on a golf course. It is supposed to be beautiful in Monterey at this time of year. Incidentally, Carmel California is a half mile from Monterey - PHOTO OP with Mayor Clint Eastwood?)

THE ABOVE IS INFORMATION FROM A SCHEDULING POINT OF VIEW. QUESTIONS REGARDING A.G.E. OR ANYTHING ELSE ARE NOT INCLUDED. IT IS MY RECOMMENDATION THAT [redacted]

If the decision is made [redacted]ill contact the two speech groups involved and negociate times etc. [redacted] I will contact Paul regarding the A.G.E. event.

D

PIRANHA

PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Ms. Karen Doyne
Pathology Practice Associates
1225 Connecticut Avenue NW
Suite 303
Washington, DC 20036

FROM: PIRANHA PRESS

DATE: OCTOBER 27, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

Senator Durenberger has entered into an exclusive arrangement with us under which we handle the arrangements for the sale and promotion of his books as well as his appearances. If you have not already been contacted, you will be contacted by the law firm which represents Senator Durenberger to review the terms of our arrangement with the Senator, the legal restraints, if any, and the fees and travel arrangements for his appearance.

If you have any questions, please contact Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

E

DECEMBER 3, 1986

—— Remarks to the "Coping with Change: Rural America in Transiti 2KP
conference in Minnesota s: TC

OCTO
Rema
Fuel
oppo

DECEMBER 5, 1986

5EKP Remarks to the Hospital Corporation of California in Monterey, 5KP
c: Kerry Elliot re: what's happening in federal health ca

OCTOB
Remar
c: A

5EKP Remarks to the Pathology Practice Association in San Francisco,
Karen Doyne re: clinical lab fees/DRG's for hospital based physicians

—— Remarks to the A.G.E. Luncheon at Stanford University in Palo Alto, CA
c: Paul Hewitt re: A.G.E.

2K Remarks to representatives of Merritt Peralta Medical Center in Oakla
DECEMBER 8, 1986 CA c: Wayne Thompson RE: health issues

—— Panel discussion by the Council of State Governments Annual Meeting in
Orlando, [illegible] re: changig state/federal role CANCELLED

DECEMBER 10, 1986

—— Remarks to the A.G.E. Luncheon in Denver, Colorado c: Paul Hewitt re:
A.G.E. CANCELLED

DECEMBER 11, 1986

—— Remarks to the Health Future Foundation in Omaha, NE c: Chuch Monasee
re: it's a full day health conference

Del
3 No
0 H
2 P
1 Other

Pathology Practice Association
1225 Connecticut Ave., N.W.
Suite 303
Washington, D.C. 20036
(202) 659-4593

David Yates, M.D.
President
Stephen Bauer, M.D.
Vice President
Frederick E. Joyce, M.D.
Secretary/Treasurer
Emanuel Abrams, M.D.
Board Member
George Branam, M.D.
Board Member
Erlo Roth, M.D.
Board Member
John W. Foft, M.D.
Board Member
Kai Kristensen, M.D.
Immediate Past President

December 10, 1986

TO: Frederick Joyce, M.D.
George Branam, M.D.
Erlo Roth, M.D.

FROM: Paul Johnson

RE: PPA Annual Meeting

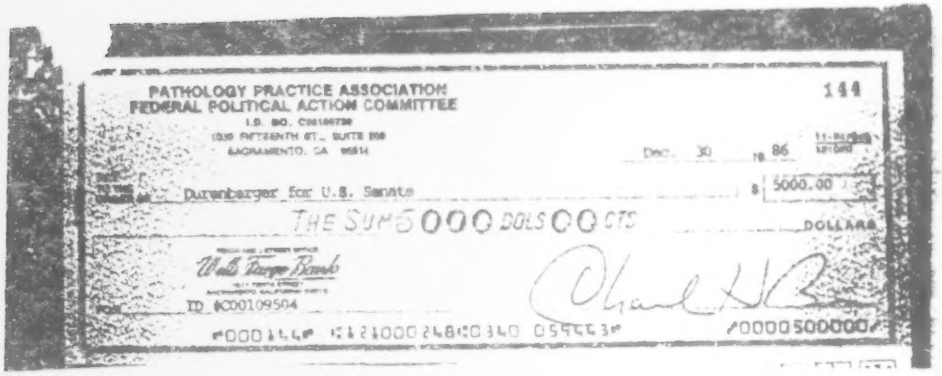
In general, the PPA's meetings and speaking engagements went very well in San Francisco. The attendance could have been better, but both Senator Durenberger and Chip Kahn provided informative speeches which were well received by the membership.

I have enclosed copies of all of the handouts we prepared for the meeting. This includes meeting agendas and a membership and treasurer's report.

I'll send you the minutes of the board meeting later this week, but membership development dominated the discussion. It was agreed that PPA officers and board members would take immediate action to solicit new members for the association. To aid your efforts, I have enclosed extra copies of our newest membership notice.

Please call if you have any questions.

cc: Dr. David Yates
Richard Sullivan



PATHOLOGY PRACTICE ASSOCIATION
FEDERAL POLITICAL ACTION COMMITTEE
I.D. NO. C00166730
1330 PATTERSON ST., SUITE 200
SACRAMENTO, CA 95814

144

Dec. 30 19 86

Durenberger for U.S. Senate $ 5000.00

THE SUM 5000 DOLS 00 CTS DOLLARS

Wells Fargo Bank

ID #C00109504

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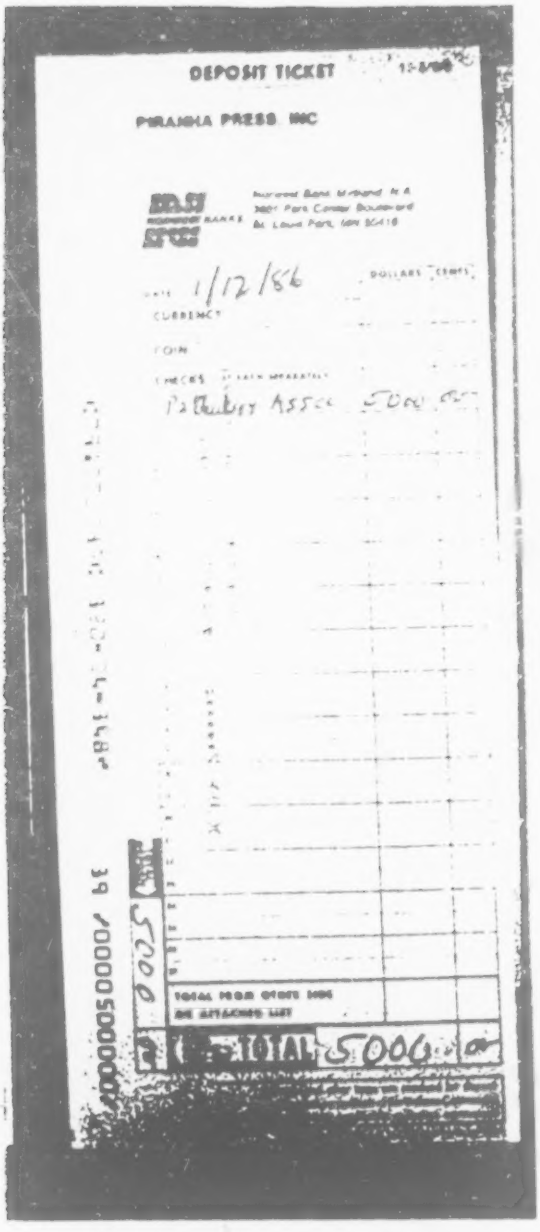


DEPOSIT TICKET

PIRAINKA PRESS INC

Harvard Bank Midland N.A.
3601 Park Center Boulevard
St. Louis Park, MN 55416

DATE 1/12/86 DOLLARS CENTS

CURRENCY

COIN

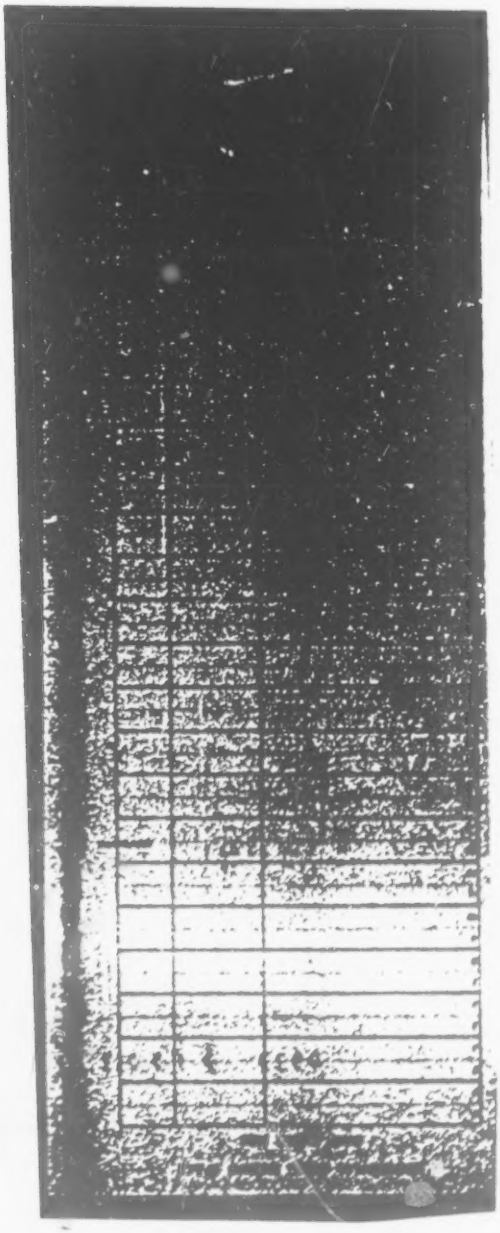
CHECKS

Patchbay Assoc 5000 00

TOTAL FROM OTHER SIDE OR ATTACHED LIST

TOTAL 5000 00

⑈000050000⑈ 39 ⑆091-7⑆8⑈



K

LAW OFFICES OF
NIELSEN, HODGSON, PARRINELLO & MUELLER
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

SAN FRANCISCO
650 CALIFORNIA STREET SUITE 2650
SAN FRANCISCO, CALIFORNIA 94108
TELEPHONE (415) 989-6800

1030 FIFTEENTH STREET SUITE 250
SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 446-8752

FILE NUMBER
5680.01/CGB

January 27, 1987

Federal Election Commission
999 E Street, N.W.
Washington, D.C. 20463

Dear Filing Officer:

Enclosed herewith please find the original of the following for Pathology Practice Association Federal PAC for the period 11-25-86 through 12-31-86.

[ ] Form 1

[X] Form 3X

[ ] Amendment to above

[ ] Other

Please endorse this transmittal letter as acknowledgement of receipt and return it in the self-addressed, stamped envelope provided.

Sincerely,

NIELSEN, HODGSON
PARRINELLO & MUELLER

cc: Secretary of State, California

REPORT OF RECEIPTS AND DISBURSEMENTS
For a Political Committee Other Than an Authorized Committee

(Summary Page)

ALIGN AREA

1 Name of Committee (In Full)
Pathology Practice Association Federal PAC

Address (Number and Street)
1030 15th Street, Suite 250

City, State and ZIP Code
Sacramento, California 95814

☐ Check here if address is different than previously reported

2 FEC Identification Number
C00160739

3 ☐ This committee qualified as a multicandidate committee during this Reporting Period on _____ (Date)

4 TYPE OF REPORT (Check appropriate boxes)

(a) ☐ April 15 Quarterly Report ☐ October 15 Quarterly Report
☐ July 15 Quarterly Report ☒ January 31 Year End Report
☐ July 31 Mid Year Report (Non-Election Year Only)
☐ Monthly Report for _____
☐ Twelfth day report preceding _____ (Type of Election)
election on _____ in the State of _____
☐ Thirtieth day report following the General Election
on _____ in the State of _____
☐ Termination Report

(b) Is this Report an Amendment?
☐ YES ☒ NO

ALIGN AREA

SUMMARY	COLUMN A This Period	COLUMN B Calendar Year-to-Date
5 Covering Period 11-25-86 through 12-31-86		
6 (a) Cash on hand January 1, 19 86		$ 7,209.35
(b) Cash on Hand at Beginning of Reporting Period	$ 10,355.06	
(c) Total Receipts (from Line 18)	$ 45.59	$ 11,194.99
(d) Subtotal (add Lines 6(b) and 6(c) for Column A and Lines 6(a) and 6(c) for Column B)	$ 10,400.65	$ 18,404.34
7 Total Disbursements (from Line 28)	$ 7,344.62	$ 15,348.31
8 Cash on Hand at Close of Reporting Period (subtract Line 7 from Line 6(d))	$ 3,056.03	$ 3,056.03
9 [illegible]hts and Obligations Owed TO The Committee (Itemize all on Schedule C or Schedule D)	$ 0	
10 Debts and Obligations Owed BY the Committee (Itemize all on Schedule C or Schedule D)	$ 0	

I certify that I have examined this Report and to the best of my knowledge and belief it is true, correct and complete.

Charles H. Bell, Jr.
Type or Print Name of Treasurer

[signature]
SIGNATURE OF TREASURER

1-26-87
Date

For further information contact:
Federal Election Commission
Toll Free 800 424 9530
Local 202 523 4068

NOTE: Submission of false, erroneous, or incomplete information may subject the person signing this report to the penalties of 2 U.S.C. § 437g.

5680.01/CGB

All previous versions of FEC FORM 3 and FEC FORM 3a are obsolete and should no longer be used.

FEC FORM 3X (3/80)

M

N

DETAILED SUMMARY PAGE
of Receipts and Disbursements
(Page 2, FEC FORM 3X)

Name of Committee (in Full): Pathology Practice Association Federal PAC

Report Covering this Period: From: 11-25-86 To: 12-31-86

	COLUMN A Total This Period	COLUMN B Calendar Year-To-Date	
I. RECEIPTS			
11. CONTRIBUTIONS (other than loans) FROM:			
(a) Individuals/Persons Other Than Political Committees	0	10,875.00	11(a)
(Memo Entry Unitemized $ 0)			
(b) Political Party Committees	-0-	-0-	11(b)
(c) Other Political Committees	-0-	-0-	11(c)
(d) TOTAL CONTRIBUTIONS (other than loans) (add 11(a), 11(b) and 11(c))	0	10,875.00	11(d)
12. TRANSFERS FROM AFFILIATED/OTHER PARTY COMMITTEES	-0-	-0-	12
13. ALL LOANS RECEIVED	-0-	-0-	13
14. LOAN REPAYMENTS RECEIVED	-0-	-0-	14
15. OFFSETS TO OPERATING EXPENDITURES (Refunds, Rebates, etc.)	-0-	-0-	15
16. REFUNDS OF CONTRIBUTIONS MADE TO FEDERAL CANDIDATES AND OTHER POLITICAL COMMITTEES	-0-	-0-	16
17. OTHER RECEIPTS (Dividends, Interest, etc.)	45.59	319.99	17
18. TOTAL RECEIPTS (Add 11(d), 12, 13, 14, 15, 16 and 17)	45.59	11,194.99	18
II. DISBURSEMENTS			
19. OPERATING EXPENDITURES	2,344.62	5,948.31	19
20. TRANSFERS TO AFFILIATED/OTHER PARTY COMMITTEES	-0-	-0-	20
21. CONTRIBUTIONS TO FEDERAL CANDIDATES AND OTHER POLITICAL COMMITTEES	5,000.00	9,400.00	21
22. INDEPENDENT EXPENDITURES (use Schedule E)	-0-	-0-	22
23. COORDINATED EXPENDITURES MADE BY PARTY COMMITTEES (2 U.S.C. § 441 a(d)) (Use Schedule F)	-0-	-0-	23
24. LOAN REPAYMENTS MADE	-0-	-0-	24
25. LOANS MADE	-0-	-0-	25
26. REFUNDS OF CONTRIBUTIONS TO			
(a) Individuals/Persons Other Than Political Committees	-0-	-0-	26(a)
(b) Political Party Committees	-0-	-0-	26(b)
(c) Other Political Committees	-0-	-0-	26(c)
(d) TOTAL CONTRIBUTION REFUNDS (Add 26(a), 26(b) and 26(c))	-0-	-0-	26(d)
27. OTHER DISBURSEMENTS	0	0	27
28. TOTAL DISBURSEMENTS (add lines 19, 20, 21, 22, 23, 24, 25, 26(d) and 27)	7,344.62	15,348.31	28
III. NET CONTRIBUTIONS AND NET OPERATING EXPENDITURES			
29. TOTAL CONTRIBUTIONS (other than loans) from Line 11(d)	0	10,875.00	29
30. TOTAL CONTRIBUTION REFUNDS from Line 26(d)	-0-	-0-	30
31. NET CONTRIBUTIONS (other than loans) (Subtract Line 30 from Line 29)	0	10,875.00	31
32. TOTAL OPERATING EXPENDITURES from Line 19	2,344.62	5,948.31	32
33. OFFSETS TO OPERATING EXPENDITURES from Line 15	-0-	-0-	33
34. NET OPERATING EXPENDITURES (Subtract Line 33 from Line 32)	2,344.62	5,948.31	34

FL 0000005

SCHEDULE B — ITEMIZED DISBURSEMENTS

Page 1 of 1 for LINE NUMBER 19
(Use separate schedule(s) for each category of the Detailed Summary Page)

Any information copied from such Reports and Statements may not be sold or used by any person for the purpose of soliciting contributions or for commercial purposes, other than using the name and address of any political committee to solicit contributions from such committee.

Name of Committee (in Full)

Pathology Practice Association Federal PAC

	Purpose of Disbursement	Date (month, day, year)	Amount of Each Disbursement This Period
A. Full Name, Mailing Address and ZIP Code Nielsen, Hodgson, Parrinell & Mueller 1030 15th Street, Suite 250 Sacramento, CA 95814	Legal & Administrative Services Disbursement for ☐ Primary ☐ General ☐ Other (specify)	12-5-86	251.00
B. Full Name, Mailing Address and ZIP Code Senator David Durenberger 8120 Penn Ave South Minneapolis, MN 55431	Travel Expenses Disbursement for ☐ Primary ☐ General ☐ Other (specify)	12-30-86	714.00
C. Full Name, Mailing Address and ZIP Code Mr. Charles N. Kahn III 1106 Longworth H.O.B. Washington, D.C. 20515	Honorarium Disbursement for ☐ Primary ☐ General ☐ Other (specify)	12-30-86	750.00
D. Full Name, Mailing Address and ZIP Code Mr. Charles N. Kahn III 1106 Longworth H.O.B. Washington, D.C. 20515	Travel Expenses Disbursement for ☐ Primary ☐ General ☐ Other (specify)	12-30-86	629.62
E. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
F. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
G. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
H. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
I. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
SUBTOTAL of Disbursements This Page (optional)			2,344.62
TOTAL This Period (last page this line number only)			2,344.62

0

SCHEDULE B

ITEMIZED DISBURSEMENTS

Page 1 of 1 for LINE NUMBER 21
(Use separate schedule(s) for each category of the Detailed Summary Page)

Any information copied from such Reports and Statements may not be sold or used by any person for the purpose of soliciting contributions or for commercial purposes, other than using the name and address of any political committee to solicit contributions from such committee.

Name of Committee (in Full)
Pathology Practice Association Federal Political Action Committee

	Purpose of Disbursement	Date (month, day, year)	Amount of Each Disbursement This Period
A. Full Name, Mailing Address and ZIP Code Durenberger for U.S. Senate 8120 Penn Ave. South Minneapolis, MN 55431	Contribution FEC C00109504 Disbursement for: ☐ Primary ☒ General ☐ Other (specify)	12-30-86	5,000.00
B. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
C. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
D. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
E. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
F. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
G. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
H. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
I. Full Name, Mailing Address and ZIP Code	Purpose of Disbursement Disbursement for: ☐ Primary ☐ General ☐ Other (specify)	Date (month, day, year)	Amount of Each Disbursement This Period
SUBTOTAL of Disbursements This Page (optional)			
TOTAL This Period (last page this line number only)			5,000.00

P

L. Pinzelt F41

December 13, 1984

TO: J. Curti
G. Denison
C. Hardwick
M. Hughes
F. Price
W. Steere
P. Tombros
R. Vastola
R. Wroblewski

FROM: C. Lindsay

RE: Presidents Forum V - April 26, 27 & 28, 1985

There is a meeting scheduled Monday, December 17th at 11:00 a.m. in the 14th Floor Conference Room to discuss the following items for the Presidents Forum program:

Item 1: Speakers. Attachment I is a revision of the program tentatively approved at the last meeting. Added to the topics are potential speakers gleaned from an intensive literature review. A substantive portion of the meeting will be devoted to the selection of speakers and approval of the final program. I'd appreciate your reviewing the choices prior to the meeting to facilitate discussion.

Item 2: Slide Show Theme. Attachment II lists a number of optional themes for consideration. I'd like to obtain approval for a creative direction so that work can proceed promptly.

Item 3: Expected Attendance. MedComEd staff has been in the process of calling physician guests all week. By Monday, we should have some indication of expected attendance for the chosen April date.

Item 4: Keynote Speaker. Harry Walker is meeting with Jean Kirkpatrick today or tomorrow. By Monday, we should have some indication of interest.

Atts.

SPECIAL
COUNSEL
HEARING
EX. 182

A

PFZ 15

Attachment I

PRESIDENTS FORUM V

Saturday, April 27

8:15AM - 9:15AM "Redeployment of Resources in Healthcare"
(Choose 1 from 2 speakers)

** Senator David Durenberger (R-Minn)

- Specialist in healthcare legislation
- Particular area of expertise: Ambulatory Care
- Successfully backed plan to encourage offering employees a choice of insurers.
- Experience drawn from Minnesota's HMO's and his preference for market solutions
- Chaired Intergovernmental Relations Subcommittee of Governmental Affairs
- Chairman of Senate Subcommittee on Health
- JD - University of Minnesota (1959)
- Key legislator in Senate on "new federalism" issues.

Margaret M. Heckler

- Secretary of Health and Human Services
- Member of 90th to 97th Congresses
- Member of Joint Economic Committee, Science and Technology Committee
- Believes objective of healthcare: to produce a more competitive marketplace rather than to impose more regulation, while allowing the individual patient greater freedom of choice (see interview Bus. Week 11/26/84)

9:15AM - 10:15AM "Investor-Owned and Not-for-Profit Hospitals: Formation of Joint Ventures"
(Two speakers - 1 from for-profit organization
1 from not-for-profit organization)

Donald MacNaughton

- Chairman and CEO of Hospital Corporation of America
  - This investor-owned giant operates more than 350 hospitals in the US and abroad.
  - Through an acquisition program begun in the late 1960s, and recent construction programs, this company has become the world's largest hospital management company in terms of revenues, with $3.2 billion in 1982.
  - Emphasis on healthcare services will witness a subtle change from "more is better" to "more efficient is better."
  - HCA encourages hospitals to consider adding primary care units, as opposed to setting up a network of freestanding primary care centers.
  - HCA operates acute care hospitals and more psychiatric hospitals than any other U.S. operator
  - HCA operates the world's largest HMO
- Industry observers and HCA executives believe HCA's reputation and the image of the entire hospital management industry was given a boost when MacNaughton was hired.
- Formerly Chairman of the board and Chief Executive Officer at Prudential Insurance Company of America.
- MacNaughton serves on the boards of Exxon, AT&T, J&J and Prudential.
- Private law practice from 1948-54

Robert Joy Glaser, MD

- President and CEO of the Henry J. Kaiser Family Foundation since 1972
  - Kaiser Foundation is the largest secular not-for-profit system in the U.S.
  - Its major share of resources is devoted to programs in medicine, with emphasis on (a) healthcare delivery; (b) medical and paramedical education; and, (c) problems in medicine.
- Professorships at Medical School of the University of Colorado (1947-1963)
- President of Affiliated Hospitals Center, Inc. (1963-1965)
- Consulting Professor at Stanford University since 1972
- Director at Hewlett-Packard Co., Dynapol, Equitable Life Assurance Society, U.S.
- Member of the Committee on Medical Affairs at Yale University
- MD - Harvard, 1943

C

11:30AM - 12:30PM "Integration of Clinical Medicine with Management"
(One speaker)

Victor Fuchs

- Educator, author
- Professor at several educational institutions including Columbia and NYU
- Member of National Academy of Science Institute of Medicine
- Professor of Economics at Stanford University and Medical School
- Authored a multitude of books on the economics of health and the service industries including The Economics of Health and Medical Care, 1972; Who Shall Live? Health Economics, and Social Choice, 1975; Economic Aspects of Health, 1972.

- (Note: One chapter in Who Shall Live? is entitled "The Physician: The Captain of the Team." Victor Fuchs suggests in his 1983 edition that the chapter could be more appropriately titled "Physicians: The Co-Captain of the Team.")

- M.A., Ph.D Columbia University

10:35AM - 11:30AM Physicians: New Management Structures"
(Choose 2 from 3 speakers)

Stephen M. Shortell, PhD

- A.C. Buehler distinguished professor of hospital and health services management, Northwestern University, Evanston, IL
- Shortell predicts the turmoil will increase when prospective pricing extends to the private sector - a movement he thinks is inevitable
- At a 1984 meeting of the American Hospital Association, Shortell cited a prediction of some observers that within the next 10 years, US health care will be dominated by about 20 large firms - a few large multispecialty group practice clinics, some major insurance companies and some very large multiunit hospital systems.
- Contributes articles to professional journals including "10 Guidelines for success of hospital-physicians partnerships" Modern Healthcare 8/1/84
- Shortell believes hospital staffing structure is on the decline as hospital physician rivalry grows

Leif C. Beck, LL.B.,

- Lawyer and Certified Professional Business Consultant
- Chairman of Health Care Consulting Inc. of Bala Cynwyd, PA
- Editorial Consultant for Medical Economics, 6/25/84
- Believes we're witnessing end of small medical practices and therefore advocating larger groups for physicians. These groups provide marketing clout, range of service, negotiating position, management expertise and wide availability.

Russell B. Roth, MD

- Former AMA President (1973-74)
- Disturbed by totally independent, freestanding surgery and emergency centers which lack the extensive monitoring that safeguards quality of care in accredited hospitals. He distinguished between entrepreneurs who are seeking big profits from patients, and those who are pushing products.
- Public speaker on science and socio-economic medical subjects since 1946
- Member of Health Insurance Benefits Advisory Council (1975-78)
- Member of Joint Commission on Accreditation Hospitals since 1975
- Member of PA Governor's Advisory Health Board (1956-72)

E

PRESIDENTS FORUM V

Sunday, April 28

8:15AM - 9:15AM "Home Healthcare: The Pivotal Role of Physicians" (Choose 1 from 3 speakers)

** Senator Orrin G. Hatch (R-Utah)

- Chairman of Labor and Human Resources Committee, Constitution Subcommittee and Government Regulation and Paperwork SubCommittee
- Sponsored bills on comprehensive health insurance and home health care, including Bill S-139, "The Comprehensive Health Care Reform Act." Several of the bills recommend consolidated assistance by the Federal Government to the states for health promotion and disease prevention.
- J.D. - University of Pittsburgh (1962)

Kaye Daniels

- President of Hospital Home Health Care Agency HHHCA (not-for-profit), Torrence, CA - $8 million/year agency (1984-over 130,000 visits.)
- In 1977, the agency was losing money. At Daniels' urging, it formed a cooperative with 10 not-for-profit hospitals. This formation of the cooperative gave HHHCA a wider patient base.
- Corporate restructuring of HHHCA gives the 10 founding hospitals the ability to form partnerships with the agency and share in its profits.
- Spoke at the Fourth Annual conference on Home/Selfcare in Washington, DC (6/84)
- She estimates that home care accounts for only a small portion of a hospital's annual operating budget-about $500,000 to $800,000.
- Formerly Clinical Director and registered nurse at USC's student health center.

David Elliott Rogers, MD

- President of The Robert Wood Johnson Foundation; Princeton, NJ since 1972
- Member of Science Advisory Board, Mead Johnson Research Center, Evansville, IN (1961-68)
- Chairman of National Science Advisory Council of National Jewish Hospitals and Research Center (1971-73)
- Editor of Year Book of Medicine since 1966
- Member of faculty of numerous universities including Cornell, Johns Hopkins, and Vanderbilt University
- Consultant Surgeon General (1958-68)
- Consultant HEW (1969-72)

F

9:15AM - 10:30AM "Rationing of Healthcare vs. New Technology"
(Choose 2 from 3 speakers)

** William Benjamin Schwartz, MD

- Chairman of Health Policy Advisory Board, Rand Corporation since 1970
- Principal Advisor of Health Sciences Programs, Rand Corp. since 1970
- Established investigator for American Heart Association (1956-1961)
- Professor of Medicine at Tufts University and staff at New England Center Hospitals since 1950
- Chairman of the Department of Medicine of Tufts University (1971-76)
- Co-authored The Painful Prescription: Rationing Hospital Care
- Authored "U.S. Medical Cannot Do Everything for Everybody" (6/25/84)
- M.D. - Duke 1945
- Schwartz believes that (1) competition among physicians has resulted in a better geographic distribution of physicians, rather than a doubling of fees (2) demand will keep pace with physician supply because there will be more elderly and more sophisticated technology, and (3) the era of physicians being able to offer a patient anything that might help is over, and that the era of choosing what to forego for which patients on the basis of a "benefits curve" is upon us.

David Allen Jones

- Chairman, Founder, Director and CEO of Humana, Inc.
  - This leading investor-owned hospital chain ranks first in terms of profitability among the nation's major hospital management companies.
  - Humana is the only major hospital management company not engaged in the management of hospitals for others on a fee basis.
  - Humana had 1983 revenues of $1.7 billion.
- Admitted to Kentucky Bar in 1960
- Director of Royal Crown Companies, Inc.
- Director of the Advisory Commitee for the First Kentucky National Corporation and affiliates of First Kentucky Trust Company
- JD - Yale University, 1960

G

-Robert K. Jarvik, MD

- Physician - Bioengineer who invented artificial heart, the Jarvik-7 Heart
  - The device is powered by an external compressor the size of a television set, and the patient must spend the rest of his life tethered to the two plastic air hoses connected to the compressor.
  - In 1982, the machine cost $20,000.
- Head of Symbion, Inc. the Salt Lake City firm that manufactures the artificial heart.

---------- AND/OR ----------

William Castle Devries, MD

- Surgeon who implanted the first artifical heart in retired dentist Barney clark in 1982. (Only FDA authorized surgeon to perform human artificial - heart implants.)
- Instrumental in moving the nation's only FDA-sanctioned artificial heart implant program from the University of Utah to a private heart institute operated by Humana, Inc.
  - The stalled artificial heart implantation program stands to gain a major infusion of money with the move to Humana Heart Institute International. Chairman David A. Jones has pledged to underwrite the hospital charges of up to 100 heart transplant patients as long as the researchers continue to make scientific progress.
- Assistant Professor of Surgery and Chairman of the Division of Cardiovascular and Thoracic Surgery at University of Utah (1971-1979)
- Chief of Thoracic Surgery at Salt Lake VA Hospital

H

PFZ 22

10:45AM - 12:00PM "Venture Capital: Physicians as Entrepreneurs"
(Choose 2 from 4 speakers)

Ernest J. DeSalvo, M.D.

- Chairman and Founder of Medical Resources, Inc. (MRI)
  - This company is opening freestanding centers for nuclear magnetic resonance and other imaging modalities. The centers will be operated by radiologists, owned by limited partnerships and developed in joint ventures with hospitals.
  - DeSalvo predicts 2,000 outpatient imaging centers will open in the U.S. during the next five years, and MRI expects to be operating 5% of them. Since DRGs encourage providers to do many diagnostic procedures outside of the hospital, DeSalvo predicts only 1/3 of the 4,000 magnetic resonance imaging scanners expected to be sold in the U.S. by 1989 will be installed in hospitals.
  - Began business in 1979
  - 1984 - $2.5 million in revenue (Projected 1985 - $8 million in revenue
- DeSalvo practiced internal medicine and nephrology until 1981, when he decided to devote full time to building his business.

** Peter J. Farley, MD

- Entrepreneur who helped found Cetus Corporation, the California Biotechnology pioneer.
- Currently, he is backing Dr. William C. Mohlenbrook on a new venture based on a computerized system for classifying DRG categories by severity of illness.
- In May 1984, he resigned as Vice-Chairman of Cetus to finance Mohlenbrook in a company that will market the new system as a cost-control tool.
- St. Louis University Medical School.

I

Wallace A. Reed, M.D.

- Chairman of AlternaCare Corp. and President of independent 1,000 physician component of Blue Cross
- Co-founder of first independent, freestanding multispecialty outpatient surgical facility, named Surgicenter in 1970
  - In December 1983, similar independent outfits throughout the U.S. formed AlternaCare Corp. This organization intends to become a nationwide network of outpatient facilities, with financing from sale of common stock. (Merged partners accounted for 20,912 surgical cases)
- Reed believes ambulatory surgery centers introduced beneficial competitive thrust into the healthcare system
- Member of the Accreditation Council for Ambulatory Health Care Joint Commission on Accreditation of Hospitals (1975-79)
- President of the Accreditation Association for Ambulatory Health Care since 1981
- Board of Directors of Central Arizona Health Systems Agency
- Member of House Ways and Means Committee Advisory Council National Health Institute since 1975
- Anesthesiologist

Terry F. Tanner, M.D.

- In 1963, Tanner persuaded 15 colleagues to invest to form Concept, Inc., a company to design, produce and sell medical devices that other physicians envisioned.
- The debut product in 1966 was a disposable penlight for oral surgeons. Later, the product was sold commercially as map lights and swizzle stick lights.
- In 1983, sales were $20 million, compared to sales of $208,000 in 1967.
- General practitioner and industrial medical specialist

Kitty -/+ accepted 1/22/85 April 28th

Pfizer

PFIZER INC 1700 PENNSYLVANIA AVE N W SUITE 730 WASHINGTON D C 20006

STEPHEN R CONAFAY
Vice President-Government Relations
202 783 7070

11:15am Sunday

January 10, 1985

They want him to talk on ambulatory care.

The Honorable Dave Durenberger
United States Senate
375 Senate Rayburn Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

In 1983 Pfizer's Pharmaceutical Division began hosting a series of symposia for the current presidents and presidents-elect of the most important medical organizations in the United States. The purpose of these symposia, called the President's Forum, is for leaders of America's medical profession to exchange ideas amongst themselves, their European peers, elected and appointed government officials, and medical entrepreneurs and scholars. Keynote speakers have included former President Gerald Ford, former British Prime Minister Edward Heath, and Ambassador Philip Habib. Enclosed is a monograph from the last Forum for your information.

The President's Forum V is scheduled for April 27th, 28th and 29th in Florida. The program will examine the prospects of reshaping healthcare through more efficient use of medical resources. We would like to invite you to address this gathering of exceptionally accomplished leaders in health policy and medical practice on [redacted] The group would be interested in hearing your views on healthcare competition as a means to reduce healthcare cost as well as ambulatory care as a means of redeploying healthcare resources.

Pfizer will provide transportation to and from the Forum and, as an expression of our appreciation for your time and effort, is pleased to offer a [redacted] You and your wife are also invited to stay at the hotel during the entire conference, if your schedules permit.

I hope you are able to accept our invitation to meet with many of America's leading health care professionals. Please have your staff contact Jane Briskman in my office so we can begin making the arrangements.

Sincerely,

(or Hazel)

Stephen R. Conafay

SRC:stp

"Doral on the beach - Miami"

K

Pfizer

PFIZER INC., 1700 PENNSYLVANIA AVE. N.W., SUITE 730, WASHINGTON, D.C. 20006

STEPHEN R. CONAFAY
Vice President - Government Relations
202 783-7070

January 10, 1985

The Honorable Dave Durenberger
United States Senate
375 Senate Rayburn Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

In 1983 Pfizer's Pharmaceutical Division began hosting a series of symposia for the current presidents and presidents-elect of the most important medical organizations in the United States. The purpose of these symposia, called the President's Forum, is for leaders of America's medical profession to exchange ideas amongst themselves, their European peers, elected and appointed government officials, and medical entrepreneurs and scholars. Keynote speakers have included former President Gerald Ford, former British Prime Minister Edward Heath, and Ambassador Philip Habib. Enclosed is a monograph from the last Forum for your information.

The President's Forum V is scheduled for April 27th, 28th and 29th in Florida. The program will examine the prospects of reshaping healthcare through more efficient use of medical resources. We would like to invite you to address this gathering of exceptionally accomplished leaders in health policy and medical practice on Sunday morning at 8:15 a.m., on April 28th. The group would be interested in hearing your views on healthcare competition as a means to reduce healthcare cost as well as ambulatory care as a means of redeploying healthcare resources.

Pfizer will provide transportation to and from the Forum and, as an expression of our appreciation for your time and effort, is pleased to offer a $2,000 honorarium. You and your wife are also invited to stay at the hotel during the entire conference, if your schedules permit.

I hope you are able to accept our invitation to meet with many of America's leading health care professionals. Please have your staff contact Jane Briskman in my office so we can begin making the arrangements.

Sincerely,

Stephen R. Conafay

SRC:stp
cc: Ron Vanella

PFZ 26

Pfizer

PFIZER INC. 1700 PENNSYLVANIA AVE., N.W., SUITE 730, WASHINGTON, D.C. 20006

STEPHEN R. CONAFAY
Vice President-Government Relations
202 783-7070

January 10, 1985

The Honorable Orrin G. Hatch
United States Senate
135 Senate Rayburn Office Building
Washington, D.C. 20510

Dear Senator Hatch:

In 1983 Pfizer's Pharmaceutical Division began hosting a series of symposia for the current presidents and presidents-elect of the most important medical organizations in the United States. The purpose of these symposia, called the President's Forum, is for leaders of America's medical profession to exchange ideas amongst themselves, their European peers, elected and appointed government officials, and medical entrepreneurs and scholars. Keynote speakers have included former President Gerald Ford, former British Prime Minister Edward Heath, and Ambassador Philip Habib. I have enclosed a monograph from the last Forum for your information.

President's Forum V is scheduled for April 27th, 28th and 29th in Florida. The program will examine the prospects of reshaping healthcare through more efficient use of medical resources. We would like to invite you to address this gathering of exceptionally accomplished leaders in health policy and medical practice on Saturday at morning 8:15 a.m., on April 27th. The group would be interested in hearing your views on home healthcare as a means of defraying hospital costs.

Pfizer will provide transportation to and from the Forum and, as an expression of our appreciation for your time and effort, is pleased to offer a $2,000 honorarium. You and your wife are also invited to stay at the hotel during the entire conference, if your schedules permit.

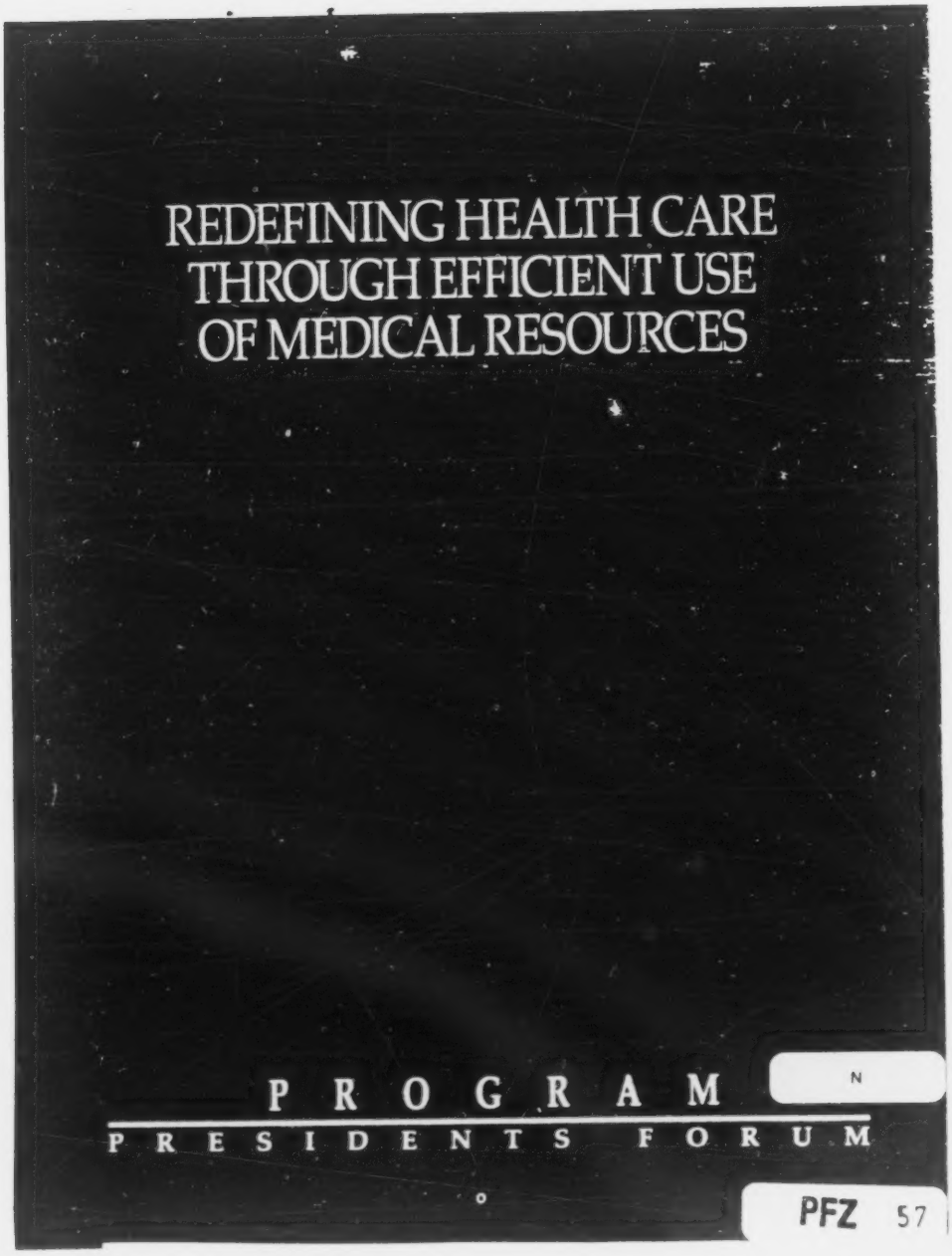
I hope you are able to accept our invitation to meet with many of America's leading health care professionals. Please have your staff contact Jane Briskman in my office so we can begin making the arrangements.

Sincerely,

Stephen R. Conafay

M

PFZ 27


REDEFINING HEALTH CARE
THROUGH EFFICIENT USE
OF MEDICAL RESOURCES
PROGRAM
PRESIDENTS FORUM
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PFZ 57

Pfizer Pharmaceuticals
is pleased to present

REDEFINING HEALTH CARE THROUGH EFFICIENT USE OF MEDICAL RESOURCES

April 26–28
Miami Beach
Florida

PFZ 58

PROGRAM CREDITS

Pfizer Pharmaceuticals would like to thank the following for their contribution to the show "Physicians in Faraway Places":

The Albert Schweitzer Fellowship
New York, New York

American Red Cross
Washington, DC

Bernice and Daniel Condit
Lafayette, California

Bible & Medical Missionary Fellowship
International Service Associates
Upper Darby, Pennsylvania

Centers for Disease Control
Atlanta, Georgia

Defense Audio Visual Agency
Washington, DC

The Flying Doctors
African Medical & Research Foundation
New York, New York

International Center for Epidemiologic and Preventive Ophthalmology
The Wilmer Institute
The Johns Hopkins School of Hygiene and Public Health
The Johns Hopkins University School of Medicine
Division of Geographic Medicine
Baltimore, Maryland

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Los Angeles, California

Rudolph von Bernuth
CARE
New York, New York

Tropical Medicine and International Travelers Clinic
Yale University
New Haven, Connecticut

United Nations
New York, New York

P

PFZ 59

PRESIDENTS FORUM AGENDA

Friday, April 26th

6:30 pm–8:45 pm	Reception and Dinner	Starlight Roof
8:45pm–9:30pm	**Keynote Speaker:** Arkady Shevchenko, *Former Soviet Ambassador to the United Nations*	

Saturday, April 27th

7:00am–7:45am	Buffet Breakfast	Spanish Court
8:00am–8:05am	**Welcome and Introduction:** Dr. Joseph T. Curti	Mediterranean East
8:05am–8:15am	**Physicians in Faraway Places**	
8:15am–9:15am	**Home Healthcare: The Pivotal Role of Physicians** Senator Orrin G. Hatch, (R–Utah)	
9:15am–10:15am	**Redeployment of America's Health Resources: Which Direction?** Dr. Uwe E. Reinhardt *Princeton University*	
10:15am–10:30am	Break	
10:30am–11:45am	**Rationing of Healthcare vs. New Technology** Dr. Peter J. Farley *Ionetyx Corporation, (Former President, Cetus Corporation)* David A. Jones *Humana, Inc.*	
11:45am–12:30pm	**Investor-Owned and Not-for-Profit Hospitals: The Resource Crunch** Michael D. Bromberg *Federation of American Hospitals* Charles M. Ewell *American Healthcare Systems*	
12:30pm–1:30pm	Luncheon	Tiki Huts on Tahiti Beach
1:30pm–5:30pm	Recreational Activities	Doral Country Club
6:30pm–7:30pm	Reception	Grand Promenade
7:30pm–8:15pm	**Keynote Speaker:** Jeane J. Kirkpatrick, *Former U.S. Ambassador to the United Nations*	Mediterranean East
8:15pm	Dinner	

Sunday, April 28th

7:00am–7:55am	Buffet Breakfast	Spanish Court
7:55am–8:00am	**Introduction:** Dr. Joseph T. Curti	Starlight Roof
8:00am–9:00am	**A Conservative's View** James J. Kilpatrick *Syndicated Columnist*	
9:00am–10:00am	**The Physician as Co-Captain of the Healthcare Team** Dr. Victor Fuchs *Stanford University*	
10:00am–10:15am	Break	
10:15am–11:00am	**The Changing Climate for Biomedical Research** Frankie Trull *Foundation for Biomedical Research*	
11:00am–12:00pm	**Redeployment of Resources in Healthcare** Senator David F. Durenberger, (R–Minn.)	
12:00pm–12:15pm	**Summation:** Dr. Joseph T. Curti	

Friday, April 26th — **Starlight Roof**

8:45 pm
Opening Address

Former Soviet Ambassador Arkady Shevchenko

Arkady Shevchenko, former Soviet Ambassador and Under Secretary General to the United Nations, became the highest ranking Soviet official ever to defect to the West when he left his country in 1978 after twenty-two years in the Soviet Foreign Service. Ambassador Shevchenko had been a trusted and personal advisor to Foreign Minister Andrei Gromyko and worked closely with all the Soviet leaders from Nikita Krushchev to Konstantin Chernenko. He was actively involved in Soviet decision-making and held the highest diplomatic rank of Ambassador Extraordinary and Plenipotentiary.

The unique story of Ambassador Shevchenko's dangerous role with the U.S. government while serving with the United Nations was revealed on a recent segment of *60 Minutes*. *Breaking with Moscow*, his first book published in the Free World, details his revelations about the Soviet elite and the rise and fall of the Soviet leaders. The book, which came out in February of this year, was the topic of a *Time Magazine* cover story as he became one of only four authors the magazine has serialized in the past ten years.

Ambassador Shevchenko was born in 1930 in the USSR and received his Ph.D. in international law from Moscow's elite Diplomatic Institute. He is currently writing a biography on Andrei Gromyko while serving as lecturer and consultant to corporations and organizations both in the U.S. and abroad.

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PFZ 61

8:05 am
Physicians in Faraway Places

A multi-screen audio-visual presentation profiling the work of physicians in remote and often exotic locations around the world.

8:15 am
Home Healthcare: The Pivotal Role of Physicians

Senator Orrin G. Hatch (R-Utah)

Senator Orrin G. Hatch has been a U.S. Senator from Utah since 1976. He is Chairman of the Labor and Human Resources Committee, the jurisdiction of which includes education, labor, health, aging, biomedical research and occupational health and safety. Senator Hatch has long been interested in the problems and complex issues challenging American healthcare. As a member of Congress, Senator Hatch has sponsored a number of bills on comprehensive health insurance and home health care. Senator Hatch believes that home healthcare offers a high-quality alternative to expensive long-term hospital care for many patients. Several of the bills recommend consolidated assistance by the Federal government to states for health promotion and disease prevention. Senator Hatch is a graduate of Brigham Young University and received a J.D. from the University of Pittsburgh.

9:15 am
Redeployment of America's Health Resources: Which Direction?

Dr. Uwe E. Reinhardt

One of the nation's most prominient healthcare economists, Uwe Reinhardt will provide an overview of the economic environment which forms the background for the current healthcare resource debates. Professor Reinhardt believes that the growing scarcity of healthcare resources is fueling a classic economic redeployment which may eventually result in a multi-tier healthcare system. Professor Reinhardt will explore the economic forces affecting hospitals, ancillary services, home and ambulatory healthcare, and the economics of new technological advances.

Professor Reinhardt is currently with the Department of Economics and the Woodrow Wilson School of Public and International Affairs at Princeton University where he has been since 1968. He is the author of *Physician Productivity and the Demand for Health Manpower* as well as numerous articles on physician and health manpower. Dr. Reinhardt received his M.A., M.Ph., and Ph.D. in Economics from Yale University.

10:30 am
Rationing of Healthcare vs. New Technology

Dr. Peter J. Farley and **David A. Jones**

The accelerating pace of technological advances in healthcare will soon create new challenges in managing healthcare resources. Developments such as the artificial heart will inevitably compete for healthcare dollars with more established treatments, while devices for long-term administration of drugs and for control of pain may ultimately shift resources from hospitals to home care. Furthermore, a new generation of therapeutics, such as the anti-cancer agents developed through gene-splicing technology and now under review by the FDA, will have a strong impact on survival rate and long-term care, growth of the geriatric population, and so forth. New technology will promote the transfer of resources from one healthcare sector to another, while also decreasing costs in some areas and generating cost increases in others.

Dr. Farley was the co-founder of the Cetus Corporation, a leader in gene-splicing technology. He is currently focused on a new venture based on a computerized system for classifying DRG categories by severity of

illness. Dr. Farley plans to develop and disseminate this new DRG system as a unique cost-control tool for hospitals. Dr. Farley is a graduate of the St. Louis University Medical School.

David Jones is the founder and Chief Executive Officer of Humana, Inc., the nation's leading investor-owned hospital chain. Under Mr. Jones' leadership, Humana has been heavily involved in incorporating new technological advances into current healthcare practice, not only in such prominent innovations as the artificial heart but also in new treatments for burns, outpatient surgery, neonatal care, and diabetes. Mr. Jones has a law degree from Yale University and a science degree from the University of Louisville, Kentucky.

11:45 am
Investor-Owned and Not-for-Profit Hospitals: The Resource Crunch

Michael D. Bromberg

Investor-owned hospitals have already begun to investigate alternative uses for diminishing healthcare dollars. Emphasis on spending has begun shifting from inpatient to outpatient care, from acute to long term treatment, from traditional hospital services to ancillary services, and so forth. Forces such as restricted availability of capital, capitation and at-risk programs which increase profit vulnerability, and competition from new healthcare ventures have encouraged investor-owned hospitals to look at joint ventures and multi-unit consolidations. Hospital management must be aware of these trends and forces, must try to anticipate their impact, and ultimately must decide how to redeploy the resources available to meet these challenges.

Michael Bromberg is Executive Director for the Federation of American Hospitals, a national trade association for investor-owned, for-profit hospitals. Mr. Bromberg has authorized numerous healthcare articles including "The Medical-Industrial Complex: Our National Defense" and "Planning for Prospective Payment." A graduate of Columbia in 1959, Mr. Bromberg earned a law degree from New York University in 1962.

Charles M. Ewell

Not-for-profit hospitals will also be affected by competition and consolidation within the industry and by pressure to control costs. One strategy for adapting to the new healthcare environment involves the merging of not-for-profit hospitals into larger management structures. These new multi-hospital groups can share managerial expertise, improve access to capital and new technology, develop preferred buyer arrangements with vendors of goods and services, and so forth.) Without any combining of financial statements or loss of autonomy, these hospitals can become more competitive with large, for-profit chains while still maintaining their indentity as community hospitals.

Charles Ewell is President and CEO of American Healthcare Systems, a national network of 31 multi-hospital systems. Established in August 1984, American Healthcare Systems links hospitals from 21 states, whose combined annual revenues total $7 billion. Mr. Ewell, a Fellow of the American College of Hospital Administrators, is the author of 40 articles on hospital management, and is a two-time recipient of the "Journal Article of the Year" Award, given by the A.C.H.A. Mr. Ewell holds a B.S. in business from Virginia Commonwealth University, an M.H.A. degree in Hospital Administration from the Medical College of Virginia, and Ph.D. in Management from the University of Wisconsin at Madison.

T PFZ 63

Saturday Evening, April 27th — Mediterranean East

7:30 pm
Keynote Address

Jeane J. Kirkpatrick

Jeane Kirkpatrick, former U.S. Ambassador to the United Nations and cabinet member under President Reagan, is a noted academic, a prolific writer and a highly respected international political figure. Ms. Kirkpatrick, known for her expertise in the area of comparative government, became the first woman to serve as Chief United States Representative to the United Nations, when President Reagan appointed her to that post in 1981.

Ms. Kirkpatrick has been active in many professional organizations, including the American and the International Political Science Associations. She has served as a board member on numerous academic and public service organizations including the Center for Strategic and International Studies, Georgetown University, and the Maryland State Board of Education, Values Education-Commission.

Ms. Kirkpatrick, born in Duncan, Oklahoma, received undergraduate degrees from Stephens College and Barnard College, and received her M.A. and Ph.D. degrees from Columbia University. She is the author of five books and numerous articles. She will be returning to Georgetown University as Professor in the Department of Government.

Sunday, April 28th — Starlight Roof

8:00 am
A Conservative's View

James J. Kilpatrick

James Kilpatrick is the nation's most widely syndicated political columnist. Upon graduation from the University of Missouri's School of Journalism in 1941, Mr. Kilpatrick began as a general reporter at the Richmond (Va.) News Leader where he later became editor in 1949 at the age of 28. During his 17 years in that capacity, he won the University of Missouri's gold medal for distinguished service to journalism and the Society of Professional Journalists' award for distinguished editorial writing. In 1964 he began writing his syndicated column, "A Conservative View," and two years later moved to Washington. There he covers Congress, the White House, and most notably the Supreme Court. Today his column is syndicated in 525 American newspapers. For 15 years Mr. Kilpatrick has served as a regular panelist on Agronsky and Company; he is a regular contributor to *National Review*; and for nine years he appeared on the CBS *60 Minutes* as a debator on "Point-Counterpoint."

9:00 am
The Physician as Co-Captain of the Healthcare Team

Dr. Victor Fuchs

The current revolution in healthcare financing is dramatically changing the relationship between physicians and administrators, between physicians and patients, and among physicians themselves. Pressure on resources, the growth of government regulation, and the complexity of organizing large-scale healthcare enterprises is accelerating the growth of management structure. Physicians will soon be forced to arrive at a compromise with the new caste of healthcare managers who will be responsible for redirecting a large share of the healthcare data base. Dr. Fuchs will explore the reasons for this revolution, its main features, and its implications for the profession of medicine.

U PFZ 64

Victor Fuchs is Professor of Economics at Stanford University's Economics Department and Medical School. He is also a Research Associate of the National Bureau of Economic Research, where he directs its program of research in health economics. Dr. Fuchs is a member of the Institute of Medicine of the National Academy of Sciences, a Fellow of the American Academy of Arts and Sciences, and a member of the Executive Committee of the American Economic Association. He is the author of six books, including the classic *Who Shall Live? Health, Economics, and Social Choice.*

10:15 am
The Changing Climate for Biomedical Research

Frankie Trull

As healthcare resources are reapportioned, spending on research will inevitably face challenges from many quarters. On Capitol Hill, for instance, the National Institutes of Health is currently fighting to halt a proposed OMB reduction in research grants from 6,000 grants a year to 4,500 over three years. Ms. Trull will discuss the current atmosphere on Capitol Hill regarding research spending, and the possible impact on the scientific and medical communities of research cuts by government. Ms. Trull also has particular knowledge of the efforts of the animal rights movement to eliminate the use of animals in biomedical research and safety testing.

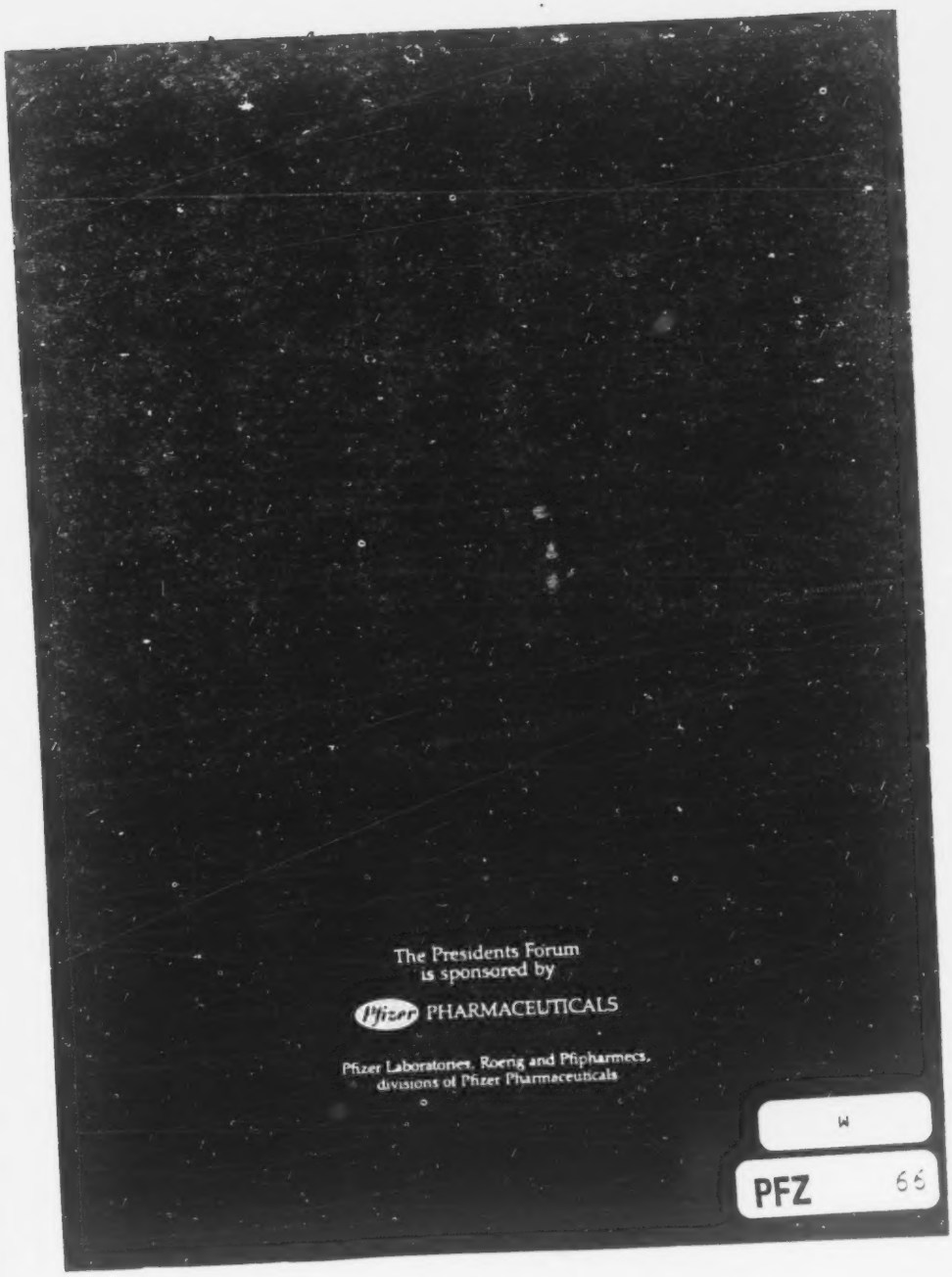
Frankie Trull has been Executive Director of the Association for Biomedical Research since 1980. Ms. Trull is a graduate of Boston University and received an M.A. in Sociology, Organizational Behavior from Tufts University.

11:00 am
Redeployment of Resources in Healthcare

Senator David F. Durenberger (R-Minn)

Actively involved in a number of committees, including Chairman of Intergovernmental Relations, Senator Durenberger is particularly well recognized for his contributions as Chairman of the Senate Finance Committee's subcommittee on health, which has responsibility for the $80 billion Medicare and Medicaid budgets. Believing that the entire U.S. system of healthcare must be reformed if costs are to be contained, he is a proponent of competition and prepaid health plans. Senator Durenberger's competition bill would give tax incentives to companies that give employees a choice of medical plans, in an effort to reduce costs to both consumers and insurers. Senator Durenberger graduated from St. John's University and received a J.D. from the University of Minnesota in 1959. His diversified career includes practicing attorney, executive secretary to Governor Harold Le Vander, counsel for Legal and Community Affairs, corporate secretary for H.B. Fuller Company, and numerous chairmanships of recreation and park associations.

PFZ 65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W
PFZ 66

PFIZER INC. 1700 PENNSYLVANIA AVE. N.W. SUITE 730 WASHINGTON, D.C. 20006

STEPHEN R. CONAFAY
Vice President-Government Relations
202 783 7070

May 1, 1985

The Honorable David Durenberger
United States Senate
375 Senate Russell Office Building
Washington, DC 20510

Dear David:

On behalf of Pfizer and all the guests at the Presidents Forum, I want to thank you for addressing our group last weekend in Florida. All the comments I've received have been most favorable and I personally enjoyed having the opportunity to spend so much time with you.

I would also like to thank Anne Kelly in your office for all her help in coordinating your trip. She is an extremely competent person and it was a pleasure to work with her.

In a few weeks, I will be forwarding a transcript of your remarks for your review. The approved version will then be distributed to all the Forum attendees.

Thank you again for joining us at the Presidents Forum. I'll be in touch.

Sincerely,

Stephen R. Conafay

P.S. you are playing to rave reviews
Hope to see you again soon. Thanks

x

PFZ 77

902314-12540

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PRINT OR TYPE PAYEE BELOW.
LIMIT PAYEE NAME TO 30 CHARACTERS.

REQUESTED BY: RICHARD VASTOLA DATE: 3/4/85
APPROVED BY (DO NOT INITIAL): Richard Vastola

ISSUE CHECK TO ORDER OF: PIRAHNA PRESS

ADDR. 1: 4504 EXCELSIOR BLVD.

CITY & STATE: MINNEAPOLIS, MN ZIP CODE: 55416 OFFICE CODE CC NO.

PAY THE SUM OF (PLEASE WRITE OUT): Two Thousand Dollars & 00/100 DOLLARS

IN PAYMENT OF: Speaker Honorarium for Presidents Forum V (on behalf of Senator David Durenberger) AMOUNT IN FIGURES: $ 2,000 00

FOR USE WHEN CHARGE IS TO ACCOUNT 1310 OR EXPENSE CODES 2409 - 2410

FOR CHARITABLE CONTRIBUTIONS OVER $50. (EXP. #2988)

SOCIAL SECURITY NO. TAX ID # 410694332

☐ BUDGET ☐ NOT BUDGETED

DIVISION HEAD APPROVAL

CORP. PROJECTS COM. MEMBER APPROVAL (IF OVER $1000 AND NOT BUDGETED)

TAX DIVISION APPROVAL

V.P. PERSONNEL APPROVAL (IF PAYEE IS AN EDUCATIONAL INSTITUTION)

CHECK NO. ☐ MAIL TO PAYEE ☒ HOLD FOR PICK UP, EXT. 2066 ☒ SEND TO FCGoerke

ACCT./EXP.	EXP. CENTER	PROJECT NO.	AMOUNT
4543	86153		2,000 00

DRM 8320-1 (REV.) 5-80

*To be completed by Accounts Payable. All other information to be completed by requestor. Not to be used in lieu of Vendor's invoices. For specific references see Corporate Accounting Manual and Corporate Procedures 1000 and 1111.

PFZ 81

PFIZER INC.
235 EAST 42ND STREET NEW YORK N.Y. 10017

VENDOR NO.	INVOICE	INVOICE AMOUNT	DISCOUNT	NET AMOUNT
68012	5-6-85	2,000.00 ✓	0.00	2,000.00
		2,000.00	0.00	NET AMOUNT PAID- 2,000.00

NY01 511638

THIS IS YOUR COPY

Pfizer

PFIZER INC.
NEW YORK, N.Y. 10017

NY01 511638

66-952
531

MO.	DAY	YEAR		AMOUNT
06	13	85	EXACTLY******2,000 DOLLARS AND 00 CENTS	2,000.00

PAY TO THE ORDER OF
[illegible] ✓
4504 EXCELSIOR BLVD
MINNEAPOLIS MINN. 55416

68012

PFIZER INC.

WACHOVIA BANK & TRUST COMPANY
GREENSBORO, N.C.

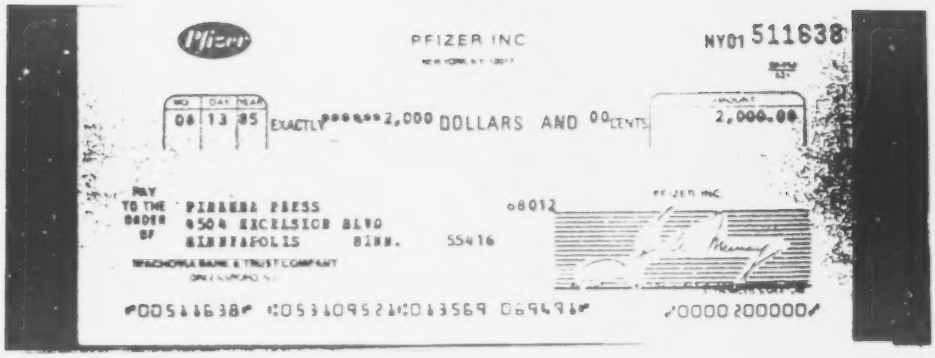
VOID

AUTHORIZED SIGNATURE

⑈005116381⑈ ⑆053100952⑆013569 069491⑈

PFZ 79

Z


PFIZER INC
NY01 511638
MO 06 DAY 13 YEAR 85
EXACTLY ****2,000 DOLLARS AND 00 CENTS
AMOUNT 2,000.00
PAY TO THE ORDER OF
PIRAMAL PRESS
6504 EXCELSIOR BLVD
MINNEAPOLIS MINN. 55416
o8012
PFIZER INC.
WACHOVIA BANK & TRUST COMPANY
005116 38 :053 0095 21:0 03569 0 69491*
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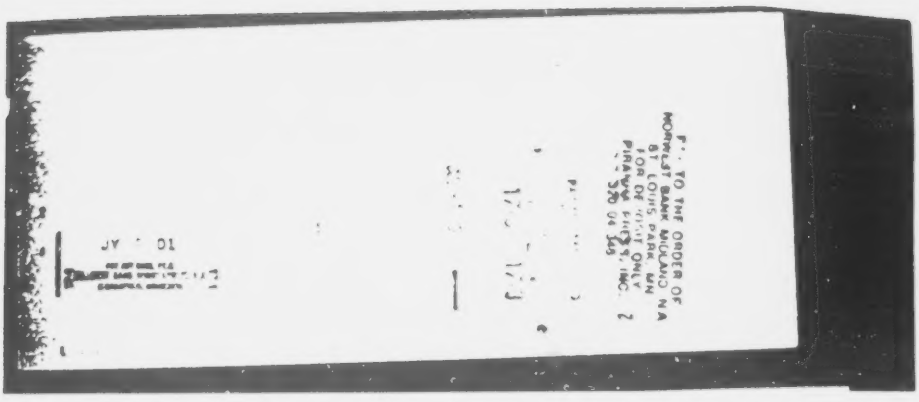


BB

PFIZER INC 235 EAST 42nd STREET NEW YORK NY 10017

June 26,1985

Ms. Ann Kelly
c/o Senator David Durenberger
375 Russell Senate Office Building
Washington, D.C. 20510

Dear Ann:

Jane Briskman of Pfizer's Washington office suggested I send the enclosed check to your attention. It represents Senator Durenberger's honorarium for the speech he gave at our Presidents Forum meeting in Miami Beach on April 28. He requested that Piranha Press be the payee.

If you have any questions at all, please don't hesitate to contact me at 212-573-2671.

Sincerely

Lynne Punzelt

Lynne Punzelt
New Program Development Analyst

Enclosure

LP/adl

cc

PFZ 85

HOPE

THE PROJECT HOPE HEALTH SCIENCES EDUCATION CENTER MILLWOOD VIRGINIA 22646 (703) 837-2100

Office of the President

9/19

July 23, 1985

The Honorable
David Durenberger
U.S. Senate
Senate Russell Office Building, Room 375
Washington, D. C. 20510

Dear Dave:

Project HOPE is convening an invitational conference on uncompensated health care in America on Thursday morning, September 19, from 9:00 a.m. to 12:30 p.m. in Washington, D.C. This meeting is being supported by the Federation of American Hospitals and the National Conference of State Legislatures. It will be held in the U.S. Capitol, room to be announced.

The purpose of this conference is to draft a consensus statement on the important public policy question of how to provide medical protection for the millions of Americans who cannot currently afford health insurance or health services and who are ineligible for existing public or employer based programs.

The invitation list (enclosed) includes leaders of business, labor, the provider community, insurers, federal, state and local governments. Key legislators who chair House and Senate subcommittees with jurisdiction over the health sphere are planning to attend the conference.

What HOPE is doing is trying to coalesce what we sense is a consensus of views on both the broad outlines of the problem and on possible solutions. We think that in short order, i.e., half of a day, a meeting of leaders such as yourselves could focus greater attention on this pressing social issue. Our goal for the meeting is to produce, in a summit conference atmosphere, a short consensus document which can be presented to the President and other elected officials, as a catalyst for the development of public policy in this area.

HOPE is serving as the convener of the conference and will provide some structure for the meeting. Dr. Wilensky, Vice President of our Health Affairs Division, and I will serve as moderators. We hope to present the results of the session at a press conference to include all participants at 12:00 noon on that day.

SPECIAL
COUNSEL
HEARING
EX. 183

A

Board of Directors: W. H. Gorzen, Chairman; Eugene R. Black, Herbert J. Bloom, D.D.S., Mrs. Edward N. Cole, J. Edward Day, W. L. Henry, L. W. Lehr, Irwin Lerner, Edwin A. Locke, Jr., Donald S. MacNaughton, Mrs. Emil Mosbacher, Jr., John O. Nelt, J. Donald Rauth, Mrs. John B. Rogan, Richard R. Shinn, Lester S. Sinness, C. Joseph Stetler, James Stewart, William B. Walsh, M.D., Richard J. Whalen, Foster B. Whitlock, Joseph D. Williams, Philip Young, Eugene M. Zuckert. Officers: William B. Walsh, M.D., President; Edwin A. Locke, Jr., Vice President; W. L. Henry, Treasurer; J. Edward Day, Secretary.

Enclosed is a suggested draft document which may be used at the session as a starting point for discussion and revision. It is an attempt to find and highlight only those areas where the wide range of interests invited may be able to agree. With that as the test, we believe much can be accomplished in moving the issue of uncompensated care to the forefront of public attention.

A background paper written by Dr. Wilensky and published in Project HOPE's quarterly journal, Health Affairs, is also enclosed for your information. Your comments on both enclosures would be helpful prior to the meeting.

I am extending this invitation to you to participate in what we regard as a special event because of your individual leadership role in shaping health policy. In the next week or two Gail Wilensky will contact you to answer any questions you may have about the purpose of the conference. We hope you will be able to help us in our effort to focus needed national attention on this problem.

Sincere personal regards,

Bill

William B. Walsh, M.D.

WBW:ar
Enclosures

B

September 9, 1985

The Honorable
David Durenberger
U.S. Senate
Senate Russell Office Building, Room 375
Washington, D.C. 20510

Dear Senator Durenberger:

I am delighted that you will be participating in the HCFA Foundation Summit conference on uncompensated hospital care. The conference will be held [redacted] A press conference will immediately follow.

Enclosed are an agenda, a list of attendees, and a revised draft statement of principles based on comments received by some but not all of the participants.

If you want to give us any other suggested changes prior to the conference, please do so by September 17. Also, if your organization has a statement on uncompensated care you would like to distribute, please send it to us in time for us to include it in a notebook each participant will receive at the meeting. Please keep in mind that the purpose of the conference is to develop for delivery to the President a statement on uncompensated care with which all the parties represented can agree.

From the response we have received, we believe that this consensus conference will contribute greatly to focusing public attention on assuring access to care for the uninsured, particularly the poor uninsured. We look forward to your help in making this effort a success.

Sincerely,

Gail Wilensky

[redacted]D.

Vice-President
Division of Health Affairs

GRW:gjm

Enclosures

C

CONFERENCE ON UNCOMPENSATED CARE

September 19, 1985

A G E N D A

09:00 a.m. - 09:15 a.m.	Dr. William B. Walsh Introduction of Participants Statement of Conference Purpose
09:15 a.m. - 09:30 a.m.	Dr. Gail Wilensky Presentation on Scope of Problem (size, shape, location)
09:30 a.m. - 10:15 a.m.	General Discussion of the Problems and Roles of Private and Public Sectors
10:15 a.m. - 11:15 a.m.	Revisions to Document - Statement of Principles
11:15 a.m. - 12:00 noon	Discussion of Next Steps Delivery of Document to the President Executive Branch Options Legislative Branch Options
12:00 noon	Press Conference

D

THE PROJECT HOPE HEALTH SCIENCES EDUCATION CENTER, MILLWOOD, VIRGINIA 22646 (703) 837-2100

September 25, 1985

The Honorable
David Durenberger
U.S. Senate
Senate Russell Office Building, Room 375
Washington, D.C. 20510

Dear Senator Durenberger:

We are delighted that you will be participating in our conference, "What Is Right About American Medical Care?" at our Millwood, Virginia campus on September 30 - October 1, 1985. As Dr. Walsh promised, I am writing to provide you with more details on the conference.

Enclosed is the tentative program agenda. As you can see, the conference begins with a reception in Carter Hall at 6:15. Your talk will begin at 8:30 p.m., and will be followed by a Question and Answer period. We anticipate that the program will end by 9:30. I will call your office to find out when and where you would like our driver to pick you up, and whether or not you will be accompanied by your wife.

If you wish to spend the evening, we would be more than happy to accommodate you with overnight lodging. The conference will continue all day Tuesday. You are welcome to join us for all or part of Tuesday, although I realize that your busy schedule may not allow you to.

We are looking forward to your visit. Please call me at (703) 837-2100 if you have any questions, and I will see you on September 30.

Sincerely,

Gail R. Wilensky

Gail R. Wilensky, Ph.D.
Vice President
Division of Health Affairs

GRW:jhb
cc: Chip Kahn

Enclosures

E

What is Right About American Medical Care?

September 30 - October 1, 1985
The Project HOPE
Health Sciences Education Center
Millwood, Virginia

F

Tuesday Morning, October 1
Moderator: John K. Iglehart
Project HOPE

7:30 Breakfast
Hunt Dining Room
Carter Hall

8:30 What the Public Thinks
Humphrey Taylor
Louis Harris and Associates

8:55 Reaction
William B. Walsh, M.D.
Project HOPE

9:00 Prescription Medication in the United States
Jerome L. Avorn, M.D.
Harvard Medical School

9:25 Reaction
Edgar G. Davis
Eli Lilly & Company

9:30 Pharmaceutical Research: How America Loses or Wins
Irwin Lerner
Hoffmann-LaRoche, Inc.

9:55 Reaction
Robert B. Helms, Ph.D.
Department of Health and Human Services

10:00 Open Discussion — Break

11:00 What's Right About the Hospital Sector, What Could We Be Doing Better?
Bruce C. Vladeck, Ph.D.
United Hospital Fund

11:25 Reaction
Gail R. Wilensky, Ph.D.
Project HOPE

11:30 Open Discussion

Tuesday Afternoon, October 1
Moderator: Gail R. Wilensky, Ph.D.
Project HOPE

12:00 Lunch
Hunt Dining Room
Carter Hall

1:30 Cost of Medical Research: Clinical, Intellectual, Ethical, and Political
Chase N. Peterson, M.D.
University of Utah

1:55 Reaction
Henry J. Aaron, Ph.D.
Brookings Institution

2:00 Medical Decision Making: What Are We Doing Well, What Could We Do Better?
David M. Eddy, M.D., Ph.D.
Duke University

2:25 Reaction
Donald K. Crandall, M.D.
American Medical Association

2:30 Reform of the Health Care System and the Condition of the Poor
Frank A. Sloan, Ph.D.
Vanderbilt University

2:55 Reaction
Jack A. Meyer, Ph.D.
American Enterprise Institute

3:00 Open Discussion

3:30 Concluding Remarks
Gail R. Wilensky, Ph.D.
Project HOPE

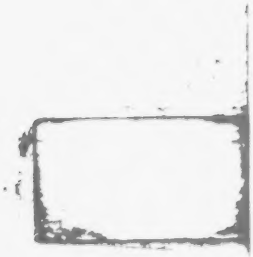
About the Conference

The purpose of this conference is to review—with respected medical and health policy professionals as well as with private and public decisionmakers—the current achievements of the U.S. health care system. This review includes an examination of the achievements and objectives of clinical medicine, pharmaceuticals, technologies, delivery systems, and financial mechanisms.

About Project Hope

For more than a quarter century, Project HOPE has improved world health by exporting the skills and resources of American medical professionals and corporations. Best known for the S.S. HOPE, the world's first peacetime hospital ship, HOPE medical education programs have trained health professionals in more than 30 countries. Project Hope is supported by charitable contributions from American citizens, corporations, and foundations, and by grants from the U.S. government for specific programs.

The Project HOPE Center for Health Affairs is a private, nonprofit policy center that provides objective research and policy analysis to help develop solutions for problems in the U.S. health system. Founded in 1982 as part of Project HOPE, the Center has a special interest in the role of the private sector and state and local governments in moderating the rise of health expenditures. *Health Affairs,* a multidisciplinary journal, is a quarterly publication of Project HOPE designed to encompass the diverse viewpoints found in the health care arena—the professions, industry, labor, government, and the academic community.



PROJECT HOPE

H

CHECK REQUEST FORM

TO: FINANCE DEPARTMENT

Please issue check as follows:

PAYABLE TO: The Honorable
David Durenberger
U.S. Senate
Senate Russell Office Building, Room 375
Washington, D.C. 20510

[X] Routine [ ] Hand Check: _____
date required

Amount: $2,000 Date: October 18, 1985

Department Head Approval: _____

Requested by: Jean McGowan

Explanation: Honorarium for conference
"What Is Right About American Medical Care"
September 30 - October 1, 1985

RETURN CHECK TO:
Jean McGowan

APPL | COMPANY NUMBER | BATCH NO | VOUCHER NUMBER (10-15)

CARD | VENDOR NUMBER (16-26) | DUE DATE MO DA YR (74-79) | CODE EITHER TERMS CODE OR DISCOUNT AMOUNT AND DUE DATE | Terms

[ ] 405 CHECK REQUEST

For Finance Use Only

TRANS CODE (36-38): 01 - UNPAID VOUCHER; 02 - DATE CORRECTION; 09 - PAID VOUCHER

INVOICE DATE MO DA YR (37-42) | BEFORE TAX & FRT INVOICE AMOUNT M THOU HUND CTS (43-57)

CARD	ITEM	ORGANIZATION DIV DEPT (18-23)	ACCOUNT NUMBER (24-31)	REF 1 (32-34)	AMOUNT M THOU HUND CTS (54-63)
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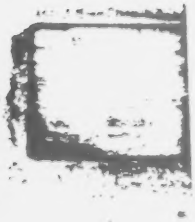
3					

Called Chase for original ticket
Called 10-23 9-30-
10-1-

Called SS Durenberger

47[redacted] 36 4240
SS
224-9474
224-9477 Jodi

Piranha Press
4504 Excelsior Blvd.
Minn. 55416



Hold-up
check request
until we hear
from Jodi -
Payable to:

K

① Make arrangement to pick up around 5:00
[illegible] at 5:00 - [illegible]
when?

5:30
Corner of Delaware & C St N.E

② Is another staff person coming?

NJ

Jodi Mattoon
244-9477

return tonight home going Arlington

L

CHECK REQUEST FORM

TO: FINANCE DEPARTMENT

Please issue check as follows:

PAYABLE TO: Piranha Press
4504 Excelsior Boulevard
Minneapolis, Minnesota 55416

RETURN CHECK TO:

Jean McGowan

[X] Routine [ ] Hand Check: _____
date required

Amount: $2,000 Date: October 31, 1985

Department Head Approval: _____

Requested by: Jean McGowan

Explanation: (Sen. Durenberger) Honorarium for conference

"What Is Right About American Medical Care"

Sept. 30 - Oct. 1, 1985

APPL | COMPANY NUMBER | BATCH NO | VOUCHER NUMBER

CARD | VENDOR NUMBER | DUE DATE (MO DA YR) | CODE EITHER TERMS CODE OR DISCOUNT AMOUNT AND DUE DATE

For Finance Use Only

[ ] 405 CHECK REQUEST

TRANS CODE: 01 - UNPAID VOUCHER; 02 - DATE CORRECTION; 09 - PAID VOUCHER

INVOICE DATE (MO DA YR) | BEFORE TAX & FRT INVOICE AMOUNT (M THOU HUND CTS)

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HOPE — THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC.
Millwood, Virginia 22646

No. 01316

DATE 11-07-85

INVOICE / CONTRACT	INVOICE DATE	DESCRIPTION	VOUCHER NO	GROSS AMOUNT	DISCOUNT AMOUNT	NET AMOUNT
	10-31-85	CHECK REQUEST	100510	200000	00	200000
			TOTALS	200000	00	200000

PLEASE DETACH BEFORE DEPOSITING
ATTACHED CHECK IS IN SETTLEMENT OF ACCOUNT AS STATED ABOVE

PROJECT HOPE — THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC.
Millwood, Virginia 22646

FARMERS & MERCHANTS NATIONAL BANK
WINCHESTER, VIRGINIA

No. 013169

INVOICE OR CONTRACT NO

DATE 11-07-85

56-13
514

PAY EXACTLY *****2,000 DOLLARS 00 CENTS PAY EXACTLY **2,000.00

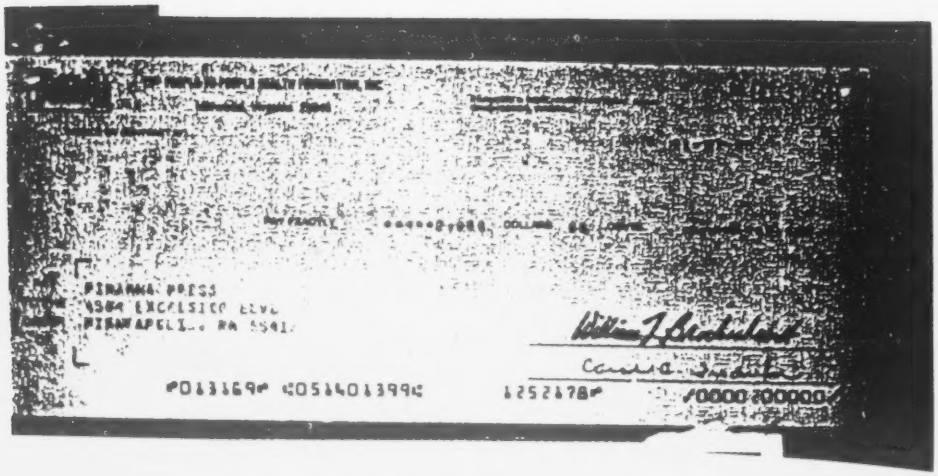
PAY TO THE ORDER OF

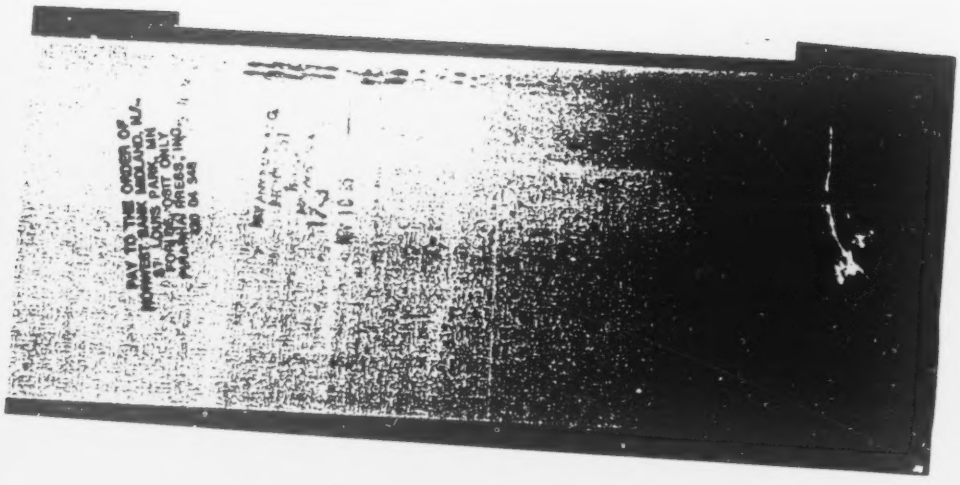
Dent 11-12-85

William J. Brockschmidt

Connie A. Snaufer

⑈013169⑈ ⑆051401399⑆ 1252178⑈ N




PAY TO THE ORDER OF
MARKET BANK MINNEAPOLIS, MN
ST. LOUIS PARK BRANCH
FOR LOAN PROCESSING ONLY
PAY ANY BANKING OFFICE
PAYABLE THROUGH
MINNEAPOLIS, MINN.
60 545

MDr

PRE-APPOINTMENT INFORMATION

EVENT DATE: TODAY'S DATE:

CONTACT: Private plane - from Dulles

TELEPHONE: Tom + Patti O'Hara either pick up or drive out

APPOINTMENT WITH: DD STAFF

FOR: Prudential Bache Conf.

TITLE: 20 top institutional investors

COMPANY: mgrs of institutional money

ISSUE: very informal
~9:00/9:30

NUMBER OF PEOPLE: PD welcome @ mtg.

ADDITIONAL NAMES: Conference over @10:30

Elbow Bch, Bermuda

Hotel:

Address:

Phone:

Senator Sasser
will speak 1st

NOTES:

PUMP A.G.E.

1. AGE (6,000)
2. 2001 to
3. Either
4.

SPECIAL COUNSEL HEARING EX. 184

A

RIDAY, MAY 2, 1986

8:00am Intern Breakfast in the Senator's Dining Room s: NN

9:00am Morning Meeting

9:30am Finance Committee Mark-Up - SD-215

11:15am Step-out of Finance to meet with Donald Alexander (former Commissioner of Internal Revenue) re: consumer interest and deductibility (to arrive at SR-154 at 11:00)

12:00noon Luncheon remarks to the NCSL state/federal assembly re: bond proposal/deductibility s: MW c: Kathy Brennan-Wiggins

12:30pm Remarks to begin

1:00am Event to end

2:00pm Finance Committee Mark-Up - SD-215

Evening:

00pm Reception for the Eisenhower Foundation sponsored Milton S. Eisenhower celebration at the Westin Hotel in the Ballroom BLACK TIE

8:00pm Dinner to begin

Late evening: PD to drive DD to Dulles for trip to Bermuda with Tom O'Hara

SATURDAY, MAY 3, 1986

9:30am Senator to participate in a discussion with representative of Prudential-Bache in Elbow Lake, Bermuda c: Tom O'Hara

REST OF AFTERNOON AND SUNDAY FREE

B

Prudential-Bache

Mark Melcher
Director of Washington Research

May 14, 1986

The Honorable Dave Durenberger
U.S. Senate
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of Prudential-Bache Washington Research, let me thank you for the outstanding presentation you gave at our Annual Investors Conference in Bermuda. Clients and guests alike said the meeting was one of the best we have hosted. Your excellent and very timely formal presentation, and enthusiastic and informative informal conversations with our clients certainly helped make it a great success.

Again, many thanks.

Sincerely,

Mark L. Melcher

C

The Prudential

The Prudential Insurance Company of America
1140 Connecticut Avenue, N.W., Washington, DC 20036
202 293-1676

May 29, 1986

Mr. Ed Fergus
Senior VP and Tax Counsel
Prudential Bache Securities
100 Gold Street
New York, NY 10292

Dear Ed,

Enclosed is a copy of the material I sent to Jane Vaccaro. As you can see from the letter, a $10,000 contribution should go to Americans for Generational Equity. This can either be a Prudential Bache check or a foundation check. In addition, a $2,000 honorarium should be issued to Piranha Press. I would appreciate your sending the checks to me and I will forward them.

I am returning the check for $2,000 payable to Americans for Generational Equity.

Sincerely,

Peggy Lenhow
straight corporate check as needed.
Tom
JKS

RECEIVED
Prudential-Bache Securities Inc.
JUN 02 1986
TAX ADMINISTRATION

Paul

The $2,000 Honorarium should be sent to Arawka Press
4504 ~~5400~~ Excelsior Blvd
Excelsior MN 55416

Thanks.
Jim.

- Paul
incl

To Mrs York.

CHRISTOPHER J ELKUS

SENIOR VICE PRESIDENT
FIDUCIARY TRUST COMPANY OF NEW YORK
TWO WORLD TRADE CENTER NEW YORK 10048 (212) 466 4100

E

Prudential-Bache Securities

M. E. Lenihan

6/6/86

Helen -

2 checks needed by Tuesday at the latest.

- 2,000 Franke Press
- 10,000 AGE

One check returned payable to AGE for 2,000.

Thx

Peg

... —50	Type 51	Sub Code 59—70	Dollar A 71—80
	7-B		

Thousand &
& No Cts

Amount Of Check

COUNTS PAYABLE

F

Securities

Payee / Vendor Name: JEANNA GRESS

Accounts Payable Use Only — Vendor I.D. Number

Address: 4504 EXCELSIOR BLVD. City: EXCELSIOR State: MN ZIP Code: 55331

Invoice No: HONORARIUM Invoice Date: 05/28/86 Gross Invoice Amount $: 2,000.00

Prepared By: BS Date: Approved By: JG 6/9 Date:

MEP No.

Co. No	Acct. No	Cost Center	Project I.D.	Distribution Amounts	T C S	1 2 3	Use Tax Code
161	790160	7020		2,000.00			
			Total Distribution	2,000.00			

Accounts Payable Use Only

Manual Check No: 00001479 | Cash: | Exp.: | Pay: | Freight:

Manual Check Date | Remit Message: [redacted] | G

Payment Due Date

Reviewed By: Date: | Approved By: JG Bachmann 6/10 Date:

Request For Check — Prudential-Bache Securities
Prudential-Bache Securities Inc

Branch (43–45)	Account (46–47–48–49–50)	Type (51)	Sub Code (69–70)	Dollar Amount (71–80)
		7-13		2000 —

Payee (CC1–37)
PIRANHA Press

Address
Return check to A. Hogan

Description Or Purpose Of This Check
HONORARIUM / Contribution

Prepared By — Date
Approved By A. D. Hogan — Date 6/9/86

Do Not Write In This Space
Check Number
Date Of Check
Checked By
Approved By

Two Thousand Dollars & No Cents

Total Amount Of Check ▶ 2000 —

CAT #4080764

ACCOUNTS PAYABLE

FORM 1418C–2

90001479

Prudential-Bache
Securities

Prudential-Bache Securities Inc
100 Gold Street, New York, NY 10292

Date
June 10, 1986

Pay

178710

To the Order Of
Piranha Press
4504 Excelsior Blvd.
Excelsior MN 55416

Amount
$2,000.00

Facsimile signature not valid for amounts of $10,000 and over

NCNB National Bank of North Carolina
Asheville, North Carolina

Non-Negotiable

Prudential-Bache Securities Inc

Prudential-Bache Securities Inc. Please detach this stub before depositing 90001479

Description

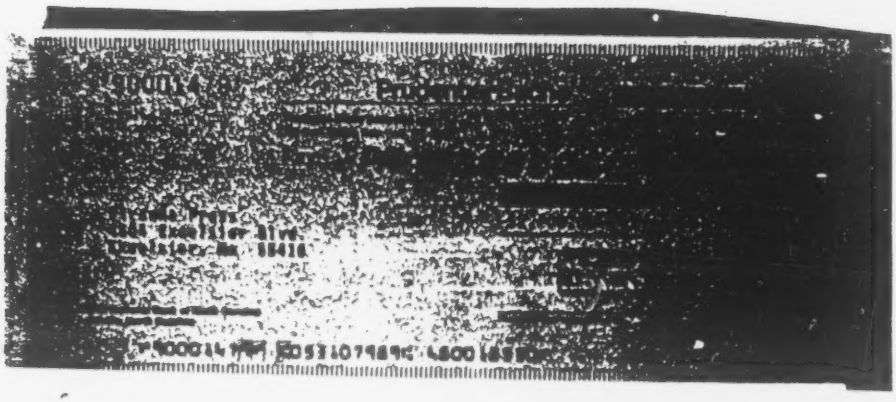
Honorarium

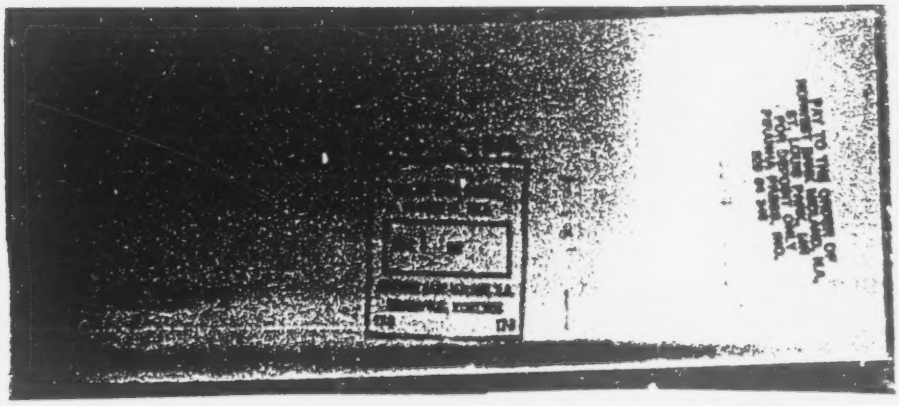
Form 5182 A

ACCOUNTS PAYABLE CONTROL

			Total Distribution		2000 00		

Manual Check No. 90001479	Cash:	Exp.:	Pay:	Freight:
Manual Check Date	Remit Message			
Payment Due Date				
Reviewed By	Date	Approved By		Date





Public Securities Association
1110 Vermont Avenue, N. W.
Suite 1075
Washington, D.C. 20005
(202)-559-5850

PSA

10/14-16 Jodi
Stay @ Biltmore
Phoenix is into dune
Mike Dougherty
341-6106

September 16, 1985

SPECIAL COUNSEL HEARING EX. 185

Honorable Dave Durenberger
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Public Securities Association, we would like to invite you to speak at the Annual Meeting of the Association in October. The Annual Meeting will be held at the Biltmore Hotel in Phoenix, Arizona, from October 14-16. We would like you to address the meeting of our Municipal Securities Division on Tuesday morning, October 15 ~7:45 11 CO in DC ~200 primarily Corporate Investment people CEO's Head of Municipal Securities Div

We note from the announced congressional schedule that this meeting coincides with the Columbus Day congressional work period, and we will be glad to make any travel arrangements that will facilitate your schedule. In addition, of course, we will be pleased to pay an honorarium. + expenses

Thank you for your consideration of this request. We hope you will be able to join us at our Annual Meeting. DD will speak @ 9:00 for 20-25 min. w/ 20 min Q&A after will be finished by 10:00.

With best wishes,

a breakfast/general session begins at 7:45am.

Sincerely,

Joan J. Rousseau
Chairman

Golf in the afn?

JJR/mm
Enclosure Stay at no if want to come earlier John Gardner's Ranch for the whole weekend.
John Turner 659-5850 * Mary McDuffie John will check the distance from the ranch to Phoenix

Headquarters: One World Trade Center, New York, NY 10048 · (212) 466-1900

→ stand for book? Is it necessary

PIRANHA

PRESS

Gary L. Diamond
Publisher

October 4, 1985

Mr. John Tumler
Public Securities Association
1110 Vermont Avenue NW
Suite 1075
Washington, DC 20005

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Tumler:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Annual Convention of Public Securities Association on October 15, 1985.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Anne Kelly
Ms. Kitty Gamble
Mr. Mike Dougherty

C

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
October 15, 1985	9:00 a.m.	Phoenix, Arizona	$5,500

D

Memo from: Heather L. Ruth

To:

Date: I need a check for Private Trust

to take to Jon Tuttle tomorrow

Jon Duremberger

~~Block tee~~

Heather.

speaker's fee

WED AM.

Public Securities Association
One World Trade Center
[illegible]
Telephone [illegible]

PSA

E

:e: Timber Press Amount: $ 5,500 —

:ess:

Check is due for Manuscript to be paid for Timber Press Book manuscript for the Perennial Primer. See attached note

Date: 10/8/95

Requested by: H Ewbank / Jaf

Approved by:

Date:

PLANTA

01-1001-220

10

5,500 —

TOS

10/9/95

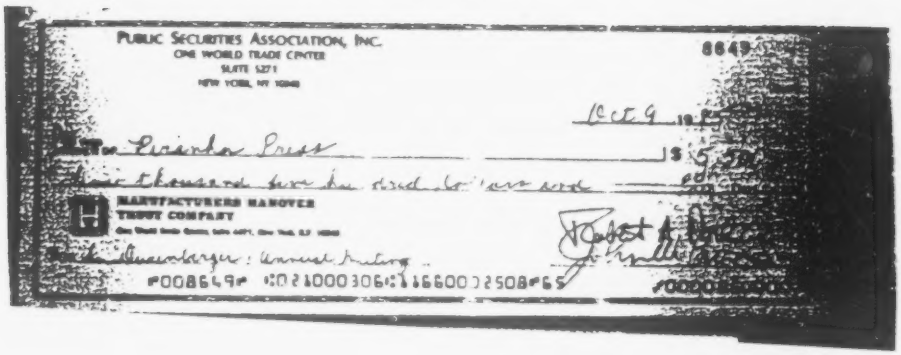
Price Unit | Line | Amount | Disc. | Net Amount | F

5,500. — 2145 pdf

10/9/95

TOTAL 5,500. — 8649

entered 10/9/95


PUBLIC SECURITIES ASSOCIATION, INC.
ONE WORLD TRADE CENTER
SUITE 5271
NEW YORK, NY 10048

8649

Oct 9 19

Pay to the order of Investor Press $ 5,

five thousand five hundred 50/100 dollars

MANUFACTURERS HANOVER TRUST COMPANY

For Answerbase: Annual Meeting

⑈008649⑈ ⑆021000306⑆166000 2508⑈65

0000 5500

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. PAUL PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
320 04 3

PUBLIC SECURITIES ASSOCIATION SPEECH

DATE: October 15, 1985

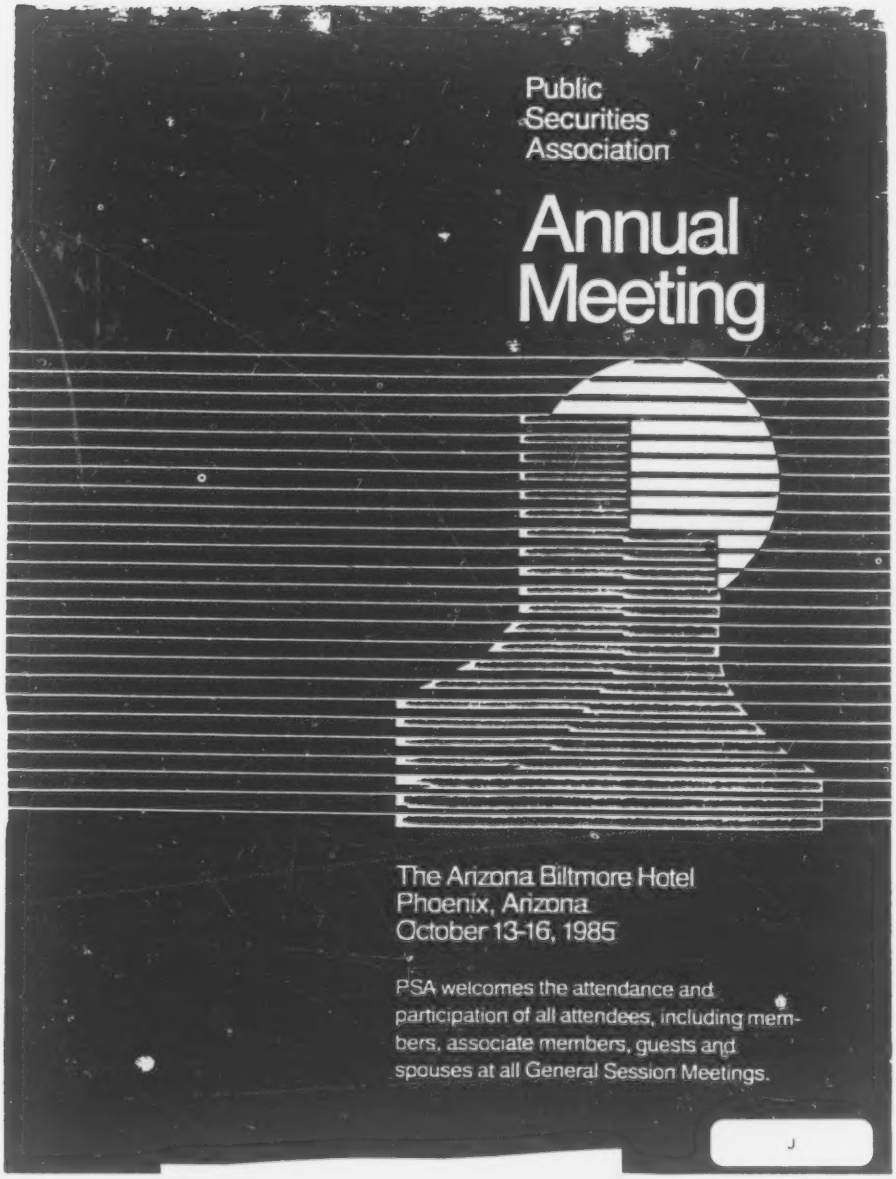
PLACE: Biltmore Hotel, Phoenix, Arizona

The group will consist of approximately 200 bankers (CEO's and Heads of Municipal Security Divisions) who would like you to discuss municipal bonds, tax exempt bond financing, and state and local financing. Margaret/IGR will provide extensive briefing material and talking points.

You will arrive in Phoenix on Monday evening and stay at the Biltmore. Original plans were to spend the evening at John Gardiner's Ranch, but due to the distance between the ranch and Phoenix, Mike Dougherty felt you should stay at the Biltmore. He would like to have dinner with you Monday evening and we are in the process of arranging that event.

The speech will revolve around the annual meeting of the Public Securities Association which begins on Oct. 14th. You will be speaking right after the breakfast/general session of the association. The breakfast begins at 7:45am. You are welcome to attend, but there will be a general meeting session during this time.

Your remarks begin at 9:00am - 20-25 minutes and 20-25 minutes Q & A - and will end at 10:00am.


Public
Securities
Association
Annual
Meeting
The Arizona Biltmore Hotel
Phoenix, Arizona
October 13-16, 1985
PSA welcomes the attendance and participation of all attendees, including members, associate members, guests and spouses at all General Session Meetings.

PROGRAM

Sunday, October 13

9:00 a.m.–5:00 p.m.	**Registration**	Main Foyer Conference Center
12:00 Noon	**Membership Committee Luncheon** Robert C. Brown, Chairman	Papago
2:00 p.m.–3:00 p.m.	**Executive Committee Meeting**	Board Room
3:00 p.m.–5:00 p.m.	**Board of Directors Meeting**	Sedona
6:00 p.m.	**"First Timers Reception"** for those attending their first annual meeting	Wrigley Suite, Terrace Court
7:00 p.m.	**Mexican Fiesta:** Cocktails, Dinner and Dancing (informal) (all attendees)	Picnic Oval

Monday, October 14

7:30 a.m.–9:15 a.m.	**Committee/Division Breakfast Meetings**	
	Government and Federal Agency Securities Division Richard M. Kelly, Chairman	Sedona
	Address by John Niehenke, Acting Assistant Secretary of Domestic Finance, U.S. Treasury Department	
	Address by Fiscal Agents: Peter Carney, Fiscal Agent, Fiscal Agency, Farm Credit Banks Gary L. Perlin, Acting Treasurer, Fannie Mae JoAnn Pierson, Director of Treasury Operations and Banking, Freddie Mac Mitchell A. Johnson, Vice President, Fiscal Agent, Sallie Mae Jean Chabot, Manager of Debt Management, Federal Home Loan Banks	
	Mortgage-Backed Securities Division Executive Committee Michael P. Mortara, Chairman	Prescott
	Municipal Operations and Compliance Committee Jeffrey H. Smith, Chairman	Papago
	Municipal Sales and Marketing Committee Peter E. Hoey, Chairman	Canyon
	Municipal Syndicate and Trading Committee Ronald E. Curvin, Chairman	Grand
9:30 a.m.–11:30 a.m.	**General Session** (all attendees)	Mesa/Flagstaff
	Welcome Heather L. Ruth, PSA Executive Director	
	Address by PSA Chairman Jean J. Rousseau	
	Election of 1986 Officers and Directors	

Nadler's Economic Outlook
Dr. Paul S. Nadler, Professor of Finance
Rutgers University, Graduate School of Management

An Investors View of Issues in the Public Securities Markets
Moderator: Samuel "Spike" Thorne, Jr., Managing Director, Scudder, Stevens and Clark
Terry M. Crow, Senior Vice President and Treasurer, Gibraltar Savings
Peter J.D. Gordon, Vice President, T. Rowe Price Associates, Inc.
Richard B. Worley, Partner, Miller, Anderson and Sherrerd

The One-Minute Manager
Dr. Kenneth Blanchard

11:30 a.m.–1:00 p.m.	**Mortgage-Backed Securities Division Regional Dealers Committee Luncheon** Gary Grear, Chairman	Grand
7:00 p.m.	**Cocktail Party** (all attendees) Dinner is open. Reservations are recommended in Hotel dining rooms.	Poolside
10:00 p.m.	**Gala After-Dinner Party** sponsored by the Government Development Bank for Puerto Rico	Grand Ballroom

Tuesday, October 15 *Morning Program*

The morning program will consist of concurrent division meetings as follows:

Municipal Division Activities

8:00 a.m.–10:00 a.m.	**General Session** Continental Breakfast	Mesa

"Capitalizing on the Myths of the Affluent Market"
Thomas Stanley, Ph.D., President, Affluent Market Research Corporation

Address by the Honorable Dave Durenberger,
U.S. Senate Finance Committee

Update on the 1985 Tax Bill
Clayton F. Brown, Chairman, Municipal Securities Division
Robert Beckel, National Strategies Consortium
James Free and James Smith, Charls E. Walker Associates
James Lindheim, Burson Marsteller

10:00 a.m.–11:30 a.m.	**Joint Meeting of Tax Bill Steering, Federal Regulation & Legislation and Public Finance Committees** Austin V. Koenen and David E. Hartley, Chairmen	Casa Grande
11:30 a.m.–1:00 p.m.	**Research and Education Committee Luncheon** Robert Muller, Chairman	Papago

Mortgage-Backed Securities Division Activities

8:30 a.m.–Noon	**General Session** Continental Breakfast	Canyon
	New Developments in Mortgage-Backed Securities Leland C. Brendsel, Acting President and CEO, Freddie Mac Jayne J. Shontell, Vice President, Fannie Mae Glenn R. Wilson, Jr., President, Ginnie Mae	
	Book-Entry of Mortgage-Backed Securities Jorge Brathwaite, Vice President, Federal Reserve Bank of New York Ronald Stewart, Vice President, MBSCC	
	Pooling SBA Guaranteed Loans Laura McKibbins, Vice President, Merrill Lynch Capital Markets	
	Update from Washington Robert A. Portnoy, PSA General Counsel	

Primary Dealers Committee Activities

7:30 a.m.–9:15 a.m.	**Breakfast Business Meeting**	Grand
9:30 a.m.–Noon	**General Session**	Flagstaff
	The Globalization of the U.S. Government Securities Market David Jones, Vice President and Manager of Fixed Income Trading, Goldman, Sachs & Co., London Noboru Takesaka, Manager of Fixed Income Trading, Merrill Lynch, Tokyo John Niehenke, Acting Assistant Secretary of Domestic Finance, U.S. Treasury Department Albert Lord, Senior Vice President and CFO, Sallie Mae Scott Pardee, Executive Vice President, Discount Corporation of New York	

Government and Federal Agencies Securities Committee Activities

7:30 a.m.–9:00 a.m.	**Breakfast Meeting** H. Jack Runnion, Jr., Chairman (members and invited guests only)	Sedona

Tuesday, October 15 *Evening Program*

7:00 p.m.	**Cocktails and Dinner** (all attendees) Entertainment: Harry Blackstone	Main Foyer, Arizona Biltmore Ballroom

Wednesday, October 16

7:30 a.m.–9:00 a.m.	**Municipal Division Executive Committee Breakfast**	Prescott
9:00 a.m.–11:00 a.m.	**Board of Directors Meeting** Continental Breakfast	Grand/Canyon

Sports and Spouse Activities

Monday, October 14

8:30 a.m.	**Ladies Breakfast** (All welcome) "Make the Rest of Your Life the Best of Your Life" by Dr. Marjorie Blanchard	Casa Grande
12:45 p.m.	**Gentlemen's Golf Tournament** Sign up at the Registration Desk by 5:00 p.m. Sunday. If you don't have a foursome, we will match you up. A shotgun Peoria system will be used. This is a Callaway-type handicap tournament. Prizes will be awarded for low gross, low net, closest to the pin and longest drive.	Links Course
1:00 p.m.	**Mixed Doubles Round Robin Tennis Tournament** Sign up when you register. First and second prizes will be awarded.	Tennis Courts

Tuesday, October 15

9:30 a.m.	**Ladies Golf Tournament** Sign up for this tournament directly with the Golf Shop at The Biltmore. If you don't have a foursome, they will match you up. Please give them your handicap—40 handicap maximum. Prizes will be awarded for low gross, low net, closest to the pin, and longest drive.	Links Course
10:00 a.m.	**Ladies Doubles Round Robin Tennis Tournament** Sign up when you register. First and second prizes will be awarded.	Tennis Courts

1985 PSA Board of Directors

*Jean J. Rousseau
Chairman
Merrill Lynch Capital Markets
—New York

*Jon S. Corzine
Vice Chairman
Goldman, Sachs & Co.
—New York

*Thomas E. Leafstrand
Treasurer
The Northern Trust Company
—Chicago

James J. Bauman
L.F. Rothschild, Unterberg, Towbin
—New York

James A. Brickley
InterFirst Bank Dallas
—Dallas

*Clayton F. Brown
Clayton F. Brown & Associates, Inc.
—Chicago

*Robert C. Brown
Norwest Capital Markets, Inc.
—Minneapolis

*Member Executive Committee

George F. Coughlin
Coughlin & Company Inc.
—Denver

David E. Hartley
Stone & Youngberg
—San Francisco

*Richard M. Kelly
Aubrey G. Lanston & Co. Inc.
—New York

Richard F. Kezer
Citibank, N.A.
—New York

*Michael P. Mortara
Salomon Brothers Inc
—New York

John J. O'Brien
Salomon Brothers Inc
—New York

Michael O. Rigg
Continental Illinois National Bank & Trust Company of Chicago
—Chicago

William D. Riley
The First Boston Corporation
—New York

Don L. Roberts
George K. Baum & Company
—Kansas City

H. Jack Runnion, Jr.
Wachovia Bank & Trust Company, N.A.
—Winston-Salem

William J. Ryan, III
Scharff & Jones, Inc.
—New Orleans

W. Stevens Sheppard
Paine Webber Real Estate Securities Inc.
—New York

Morgan B. Stark
Chemical Bank
—New York

J. Thomas Stephens
Thomas McKinnon Securities Inc.
—New York

Eric West
Citibank, N.A.
—New York

Leon A. Wiatrak
Bank of America NT & SA
—San Francisco

Annual Meeting Program Committee

S. Waite Rawls
Program Chairman
Chemical Bank

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Clayton F. Brown
& Associates, Inc.

Arthur T. Cooke
Bank of America NT&SA

Richard M. Kelly
Aubrey G. Lanston & Co.
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James Lebenthal
Lebenthal & Co.

Michael P. Mortara
Salomon Brothers, Inc

W.J. Ryan, III
Scharff & Jones, Inc.

W. Stevens Sheppard
Paine Webber Real Estate
Securities, Inc.

Brookie Warendorf
(Mrs. Robert S.L.)
Tennis Chairman
E.F. Hutton & Company, Inc.

Don L. Roberts
Men's Golf Chairman
George K. Baum
& Company

Kathy Dougherty
(Mrs. Michael E.)
Ladies Chairman
Dougherty, Dawkins,
Strand & Yost

Doris Hearty
(Mrs. James B.)
Ladies Golf Chairman
The First National Bank
of Boston

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Deputy General
Counsel

Caroline M. Benn
Director of Marketing
and Public Relations

George Brakatselos
Senior Associate

John W. Burke
Director of Finance
and Administration

Randall E. Clarke
Production Coordinator

G. Dennis Holt
Public Relations
Manager/Special
Projects

Heather L. Ruth
Executive Director

Robert A. Portnoy
Deputy Executive
Director and
General Counsel

Angelina Saraceno
Systems Manager/
Consultant

Jon R. Tumler
Director of Government
Relations

Wendy E. Wallis
Financial Policy
Analyst

Squire, Sanders
& Dempsey
Outside Counsel

Ernst & Whinney
Independent
Auditors

Support Staff

Nancy Morales Adams
Raun Burnham
Esther Clay
Nina Faunt
Deborah Gallup
Aloyce Hill
Teresa Johnson
Mary McDuffie

Public Securities Association • (New address effective October 25, 1985)
40 Broad Street, • New York, NY 10004 • 212-809-7000
Washington Office • 1110 Vermont Avenue, N.W. • Washington, D.C. 20005 • 202-659-5630

Public Securities Association
One World Trade Center
New York, New York 10048
(212) 466-1900

PSA

October 18, 1985

Senator Dave Durenberger
SR-154 Russell Senate Office Building
Washington, DC 20510

Dear Senator Durenberger:

Thank you for your excellent speech this past Tuesday morning at our Annual Meeting in Phoenix.

It was illuminating to hear your provocative and informative views on Tax Reform, which has been and will continue to be a matter of the greatest concern to us. We appreciate your fresh insights on a better way to approach the issue and look forward to working with you and your staff in the future.

Sincerely,

Jean J. Rousseau
Chairman

JJR:rmb

P

ASOCIACION DE HOSPITALES
DE PUERTO RICO
VILLA NEVAREZ PROFESSIONAL CENTER
CENTRO COMERCIAL VILLA NEVAREZ
RIO PIEDRAS, PUERTO RICO 00927
TEL. 764-0290

Jan 186

Telecopy to MH for Piranha.
DK 12/11 KG

October 10, 1985

Honorable Dave Durenberger
Chairman
Subcommittee of Health
U.S. SENATE
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Puerto Rico Hospital Association, a private non for profit organization, that represent the 83 private and public hospitals in the Commonwealth of Puerto Rico and active members of the American Hospital Association, we would be most honored to have you addressed our constituency in a special session of the Association to discuss alternatives approaches to bring about a just and equitable inclussion of the Commonwealth Hospitals in the Medicare Prospective Payment System (PPS/DRG).

We certainly hope you can include us in your busy schedule. Early January 1986 will be convenient for us. We would appreciate your prompt confirmation of your available date.

We feel that your visit and address to our health care Executives will be extremely important for the future health of our people in the Island. It will be a pleasure to have you as our guest of honor for this occasion.

Looking forward to your early response.

Respectfully,

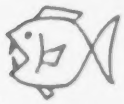
Arturo Cad[illegible], Jr., M.D.
President

avr

SPECIAL
COUNSEL
HEARING
EX. 186

A

PIRANHA



PRESS

Gary L. Diamond
Publisher

December 23, 1985

Mr. Fred Graefe
1140 Connecticut Avenue NW
Fourth Floor
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Graefe:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Puerto Rico Hospital Association on December 30, 1985.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

APPEARANCE SCHEDULE

Date	Place	Amount
December 30, 1985	Puerto Rico	$2,500

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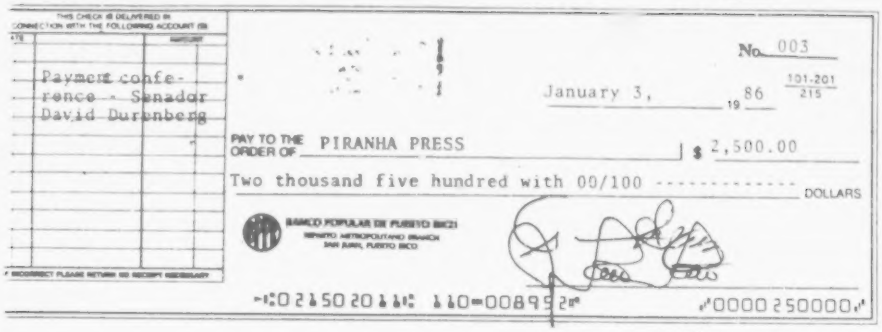

THIS CHECK IS DELIVERED IN CONNECTION WITH THE FOLLOWING ACCOUNT (S)

DATE	AMOUNT

Payment conference - Senador David Durenberg

No. 003

January 3, 19 86 101-201/215

PAY TO THE ORDER OF PIRANHA PRESS $ 2,500.00

Two thousand five hundred with 00/100 ---------- DOLLARS

BANCO POPULAR DE PUERTO RICO
RIO PIEDRAS METROPOLITANO BRANCH
SAN JUAN, PUERTO RICO

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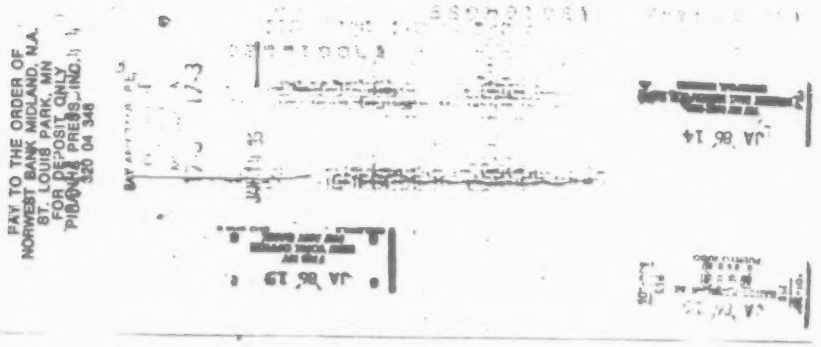

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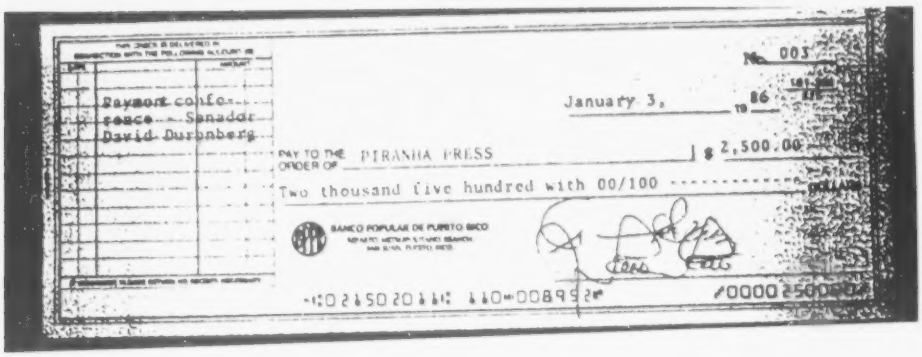
PIRANHA PRESS INC.
320 04 348



No. 003

January 3, 86

Payment confe-
rence - Senador
David Durnberg

PAY TO THE ORDER OF PIRANHA PRESS $ 2,500.00

Two thousand five hundred with 00/100 ----------

BANCO POPULAR DE PUERTO RICO

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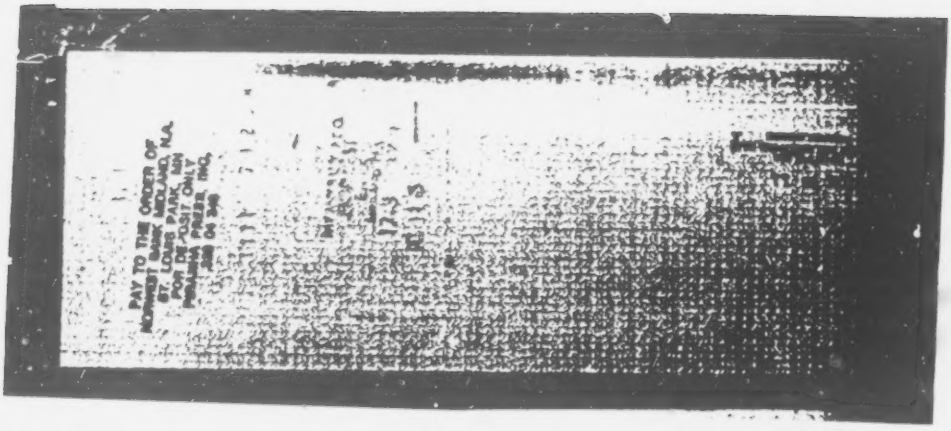

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PENALTY FOR PRIVATE USE, SEC. 588
DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE

G

TO: MAHONEY/TAMARA
FROM: JODI/DD 3/4

#2K Duffy Wall 737-0100
1317 "F" St. in his office
Has Luncheon twice a month
w/ clients & a member

OK / P.P.

Contact: Duffy Wall
@ 202-737-0100
(He's familiar w/the agreem
Date: 3/26
Time: 12:30

#2K transportation provided

3/26 @ 12:30
~~12:00n~~ -
~~1:30~~
2:00pm

14 people in attendance

Re: open/whats going on in world that week, but do get a lot of tax ques.

O.K'd 2/21/86
telecopied 2/25/86

they will send a car -
Duffy will meet in the car -

SPECIAL
COUNSEL
HEARING
EX. 187

R. DUFFY WALL & ASSOCIATES, INC.
GOVERNMENT RELATIONS CONSULTANTS
SUITE 400
1317 F STREET, N. W.
WASHINGTON, D. C. 20004

(202) 737-0100

February 21, 1986

Ms. Jodi Mathison
Office of Senator David Durenberger
United States Senate
375 Russell Senate Office Building
Washington, D.C. 20510

Dear Jodi:

Confirming our recent telephone conversation, I look forward to Senator Durenberger being the guest speaker for the luncheon at my office on Wednesday, March 26, 1986. The luncheon runs from noon until about 1:30 p.m. Attendance is limited to 12 people.

The format for the luncheon is very unstructured. Generally, the Member is asked to make a few brief comments during the luncheon and we then go around the table with each person asking a question. No written speech or other preparation is required of the Member. Many of the attendees are from out of town and the questions are generic.

Client companies and/or organizations usually in attendance include:

Allied-Signal Inc. -- New Jersey
American Council on Education -- New York
The Balcor Company -- Chicago
Footwear Retailers of America -- Washington, D.C.
JMB Realty Corporation -- Chicago
Hong Kong Trade Development Council -- New York/Washington, D.C.
Life of Virginia Insurance Company -- Richmond, Virginia
Morgan Guaranty Trust Company -- Washington, D.C.
New York State Bankers Association -- New York
Peabody Holding Company -- Washington, D.C.
Pharmaceutical Manufacturers Association -- Washington, D.C.
Torchmark Corporation -- Birmingham, Alabama
Wine & Spirits Wholesalers of America -- Washington, D.C.

Francesca Kowalski, of my office, will send you a list of those attending the week of the function. Incidentally, we do pay a $2,000 honorarium to our speakers.

Sincerely,

R. Duffy Wall

B

PIRANHA

PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Mr. Duffy Wall
1317 F Street NW
Suite 400
Washington, DC 20004

FROM: PIRANHA PRESS

DATE: FEBRUARY 26, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

We wish to advise you that Senator Durenberger has entered into an exclusive arrangement with us under which we must consent to his appearance and agree to the fees and expenses for any such appearance. Under our arrangement, you will be contacted by the law firm which represents Senator Durenberger for purposes of clarifying this arrangement and the fees to be paid.

If you have any questions, please contact Senator Durenberger's office or Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.
Kitty Gamble
Jodi Mathison

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

R. DUFFY WALL & ASSOCIATES, INC.
GOVERNMENT RELATIONS CONSULTANTS
SUITE 400
1317 F STREET, N. W.
WASHINGTON, D. C. 20004
(202) 737-0100

April 18, 1986

Mr. Gary L. Diamond
Publisher
Piranha Press
4504 Excelsior Blvd.
Minneapolis, Minnesota 55416

Dear Mr. Diamond:

Please find enclosed a check in the amount of $2,000. This is payment for the April 30th speaking engagement of Senator Dave Durenberger.

If you have any questions, please do not hesitate to call.

Sincerely,

Sharon Vaughan

Sharon Vaughan

Enclosure

cc: Ms. Jodi Mathison

D

R. DUFFY WALL & ASSOCIATES, INC.
PH. (202) 737-0100
1317 F STREET, N.W., SUITE 400
WASHINGTON, D.C. 20004

No 1144

FIRST AMERICAN BANK, N.A.
WASHINGTON, D.C.

15-4/540 3

April 18 19 86

PAY Two thousand and xx/100 DOLLARS $ 2,000.00

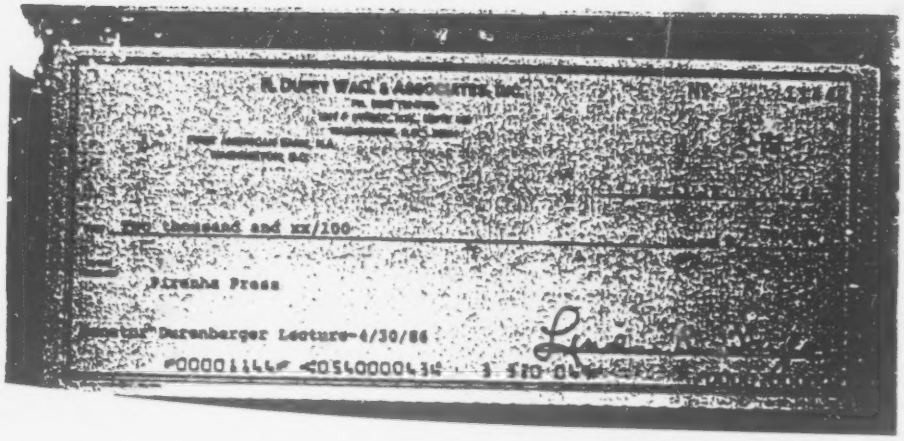
TO THE ORDER OF Piranha Press

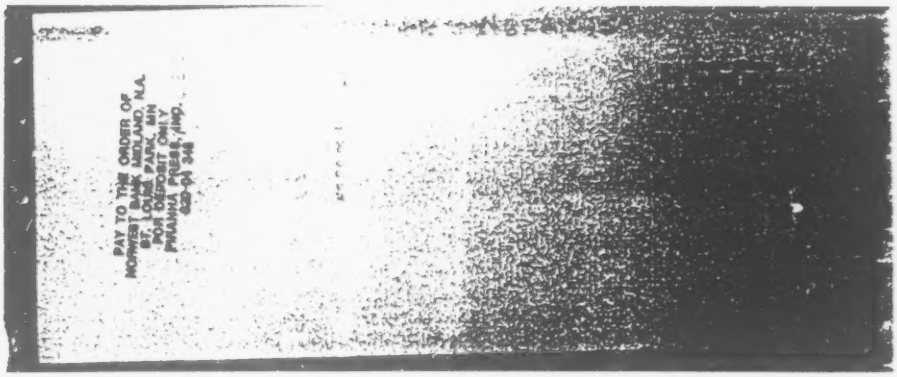
Senator Durenberger Lecture-4/30/86

Linda B. Taylor

⑈0001144⑈ ⑆054000431⑆ 3 320 049⑈ ⑈0002000000⑈

E




PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PHAUNA PUSEY, JMD.

R. DUFFY WALL & ASSOCIATES, INC.
GOVERNMENT RELATIONS CONSULTANTS
SUITE 400
1317 F STREET, N.W.
WASHINGTON, D.C. 20004
(202) 737-0100

Client Luncheon with
Senator David Durenberger
Wednesday, April 30, 1986
12:00 p.m.

Names of those who will be attending:

Mr. Ken Cole	Allied Signal Inc.
Mr. Peter T. Mangione	Footwear Retailers of America
Mr. Peter Lo	Hong Kong Commercial Affairs
Mr. Frank Sutherland menu good	Life of Virginia Insurance Company
Mr. Fritz Laird	Morgan Guaranty Trust Company
Mr. Bill Corcoran menu good	Pharmaceutical Manufacturers Association
Mr. Dallas Gwynn	The Balcor Company
Mr. Douglas W. Metz	Wine & Spirits Wholesalers of America, Inc.
Mr. David B. Rosenauer	R. Duffy Wall & Associates, Inc.
Mr. Michael Stern	R. Duffy Wall & Associates, Inc.
Mr. R. Duffy Wall	R. Duffy Wall & Associates, Inc.

Senator David Durenberger

SCHEDULING INFORMATION

O.K., if time O.K.

9/7/86 confirmed 9:00 Oct 1st

SPEECH — TYPE OF EVENT
Oct 1-2 flexible — EVENT DATE/TIME

Renewable Fuels - Nat'l Conference — GROUP NAME
or Alcohol Fuels

Contact Eric Vaughn
Phone ~~[illegible]~~ 543-3802
Key People Oil industry people, agribusiness
is an ethanol conference

Topic Challenges + opportunities for alcohol fuels → policy challenges

LOCATION OF EVENT Washington
Place Cap Hill Hyatt Regency
Room Regency A Ballroom
Phone Number
Directions

STAFFING
Briefing Memo
Photo
Speech

try 9/9:15 Wed

5/15/86
REQUEST DATE

SPEECHES
Attendance # depends on time of speech
Best time
25-75 extra tickets given
Group Size ~300 expected
Honorarium $1K → $2K O.K.'d by Eric on 6/10/86
(amount)
Room Set-Up
Introduction by Eric Vaughn
Taped ____ (y/n) Transcribed ____ (y/n)

POLLOW-UP
Eric Vaughn to meet Art Stuenkel - Chmn
Thanks Sent 10/3/86 (date)
Photo ____ (y/n) Sent ____ (date)
Photo to Media ____ (date)

Membership Lists
Received ____ (y/n)
Computerized ____ (y/n)
Filed ____ (y/n)
Regret Sent
Greeting Sent ____ (y/n)

MISCELLANEOUS

JP says Judy handles

8-4:30 on 1st Wed.
8:15-12:00 noon 2nd Thurs

Best times in morning but will take anytime

Sen. McClure speaking 8:30 Wed
Sen Zorinsky " " 9:00 Thurs

SPECIAL COUNSEL HEARING EX. 188
A

10/1-2

Renewable FUELS

Renewable Fuels Association
499 S. Capitol Street, Suite 420
Washington, D.C. 20003
(202) 484-9320

Eric Vaughn
President/Chief Executive Officer

May 15, 1986

Senator David Durenberger
154 Russell
Washington, DC 20510

Dear Senator Durenberger:

The members of the Renewable Fuels Association, a nationwide organization of private sector and governmental leaders prominent in the development and utilization of alternative energy resources, cordially invite you to be their honored guest and speaker at the 1986 National Conference on Alcohol Fuels. The Conference is scheduled for October 1-2, 1986, at the Washington, D.C. Hyatt Regency Hotel, which is located just two blocks from the Capitol.

We would wish to schedule your participation in the Conference for anytime convenient for you during our two-day session, to provide our Conference attendees with your unique perspective on the important role ethanol fuels can play in improving our national economy, establishing new "value added" markets for our farmers and enhancing our energy security.

The RFA's 1986 National Conference on Alcohol Fuels will focus on the challenges and opportunities for alcohol fuels as the most exciting new octane alternative currently on the market. This year we anticipate more than 7.2 billion gallons of ethanol/gasoline blend will be produced and sold in the United States, providing new markets for nearly 300 million bushels of grain and jobs for 45,000 American workers. Ethanol represents a superior, environmentally benign, source of octane for today's fuels and the domestic ethanol industry's dramatic growth over the past six years has positioned ethanol as one of the leading octane boosters in use today.

More than four hundred leaders from major oil companies, chemical manufacturing firms and agri-businesses attended last year's highly successful conference. If you find it possible to add great prestige to the occasion by attending as our honored guest and speaker, an even larger audience is certain this year.

We have attached a copy of the brochure from last year's conference for your review and stand ready to make any arrangements necessary to accommodate your schedule and secure your participation in our Conference. In addition, we understand how valuable your time is and we appreciate the effort required to prepare your remarks fo[redacted] available to you for your participation in the Conference.

We look forward to receiving your response to our invitation at your earliest possible convenience. Please accept our expressions of sincere thanks for considering our invitation.

With best regards, I am

Sincerely,

Eric Vaughn
President

Renewable FUELS

Renewable Fuels Association
499 S. Capitol Street, Suite 420
Washington, D.C. 20003
(202) 484-9320

Eric Vaughn
President/Chief Executive Officer

July 8, 1986

Honorable David Durenberger
U. S. Senate
154 Russell Senate Office Building
Washington, D. C. 20510

Dear Senator Durenberger:

This letter is to officially confirm your gracious acceptance of our invitation to attend the National Conference on Ethanol & Gasoline Additives to be held on October 1 - 2, 1986, as our honored guest and speaker.

The Renewable Fuels Association's 1986 National Conference on Ethanol & Gasoline Additives will be held in the Hyatt Regency Washington-Capitol Hill, which is located at 400 New Jersey Avenue, N. W. The Conference proceedings will start at 8:00 a.m. on Wednesday, October 1, and continue through early afternoon on Thursday, October 2. We have you scheduled on the agenda at approximately 8:40 - 9:00 a.m. on Wednesday morning, October 1. We will forward you a conference brochure within the next two weeks.

We will plan to work with your staff members to provide you with any information or assistance you may require in the preparation of your remarks for the Conference and we will work with your press operation to maximize media attention all across the state of Minnesota regarding your role in the Conference.

If we can answer any questions you might have or if we can provide you with any information regarding our October Conference, please call me directly.

On behalf of the members of the Renewable Fuels Association, I want to thank you for accepting our invitation to address our National Conference on Ethanol & Gasoline Additives.

With best regards, I am

Sincerely,

Eric Vaughn
President

D

Renewable Fuels Association
225 Pennsylvania Avenue, S.E., 3rd Floor
Washington, D.C. 20003
(202) 543-3802

Eric Vaughn
President/Chief Executive Officer

September 25, 1986

Ms. Judy Ericson
Legislative Assistant
Senator Durenberger
159 Russell Senate Office Building
Washington, D. C. 20510

Dear Judy:

The members of the Renewable Fuels Association are honored to have Senator Durenberger on our program agenda for the 1986 National Conference on Fuel Ethanol.

As you know, we have the Senator scheduled to address our Conference attendees at 9:00 a.m. on Wednesday, October 1, in the Regency A Ballroom of the Capitol Hill Hyatt Regency. We will plan to greet the Senator at the New Jersey Avenue entrance to the hotel and escort him to the speakers' podium. If you need any special transportation arranged, please give me a call.

The RFA's 1986 National Conference on Fuel Ethanol and Gasoline Additives will focus on the challenges and opportunities for ethanol as both a fuel extender and octane enhancer. Over the past six years the commitment and support of public officials combined with public policy initiatives designed to foster greater energy independence, have served to provide the critical stimulus to one of the most impressive examples of a successful government/industry partnership in recent years. As a result of this partnership, in 1986 alone, fuel ethanol/gasoline blend sales will reach over 8 billion gallons -- more than 8 percent of total U. S. gasoline consumption. In the wake of the EPA's decision to phase down the use of lead in gasoline, the demand for alcohol fuels as high octane alternatives to lead is expected to continue to increase, providing, in the case of ethanol, an environmentally benign octane alternative and an ever expanding market for our farmers' agricultural products.

Enclosed you will find a number of items we hope you will find useful as you prepare remarks for the Senator.

Please call me with any questions you might have.

Sincerely,

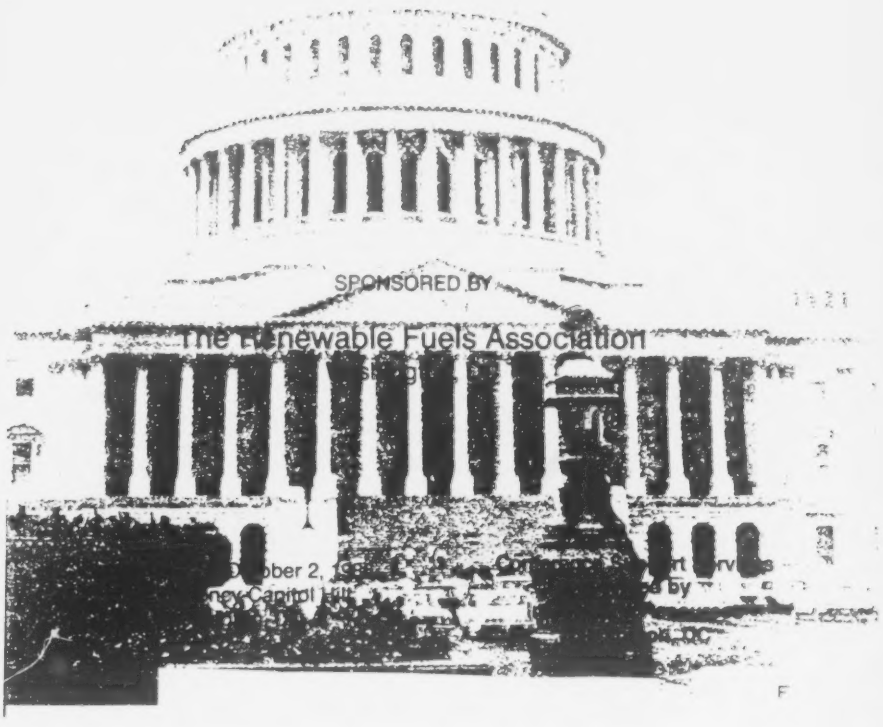
Eric Vaughn
President

Judy, You can stop by our reception Wednesday evening. Hope you can!

E

1986 NATIONAL CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES

"Changing Gasoline Composition and New Market Trends"



1986 NATIONAL CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES

"Changing Gasoline Composition and New Market Trends"

CONFERENCE OVERVIEW

Featured Speakers:

Senator James McClure (R-ID), was first elected to the U.S. Senate in 1972 after serving three terms in the U.S. House of Representatives. The Senator is currently serving as Chairman of the powerful and influential Senate Committee on Energy and Natural Resources. He will focus his remarks on future energy production and energy policy considerations for the United States.

Mr. Dan Lundberg, the nation's premier gasoline analyst, world renown marketing and pricing expert, and publisher of the *Lundberg Letter*, will address conference attendees on the "Changing World of Gasoline Marketing."

Senator Edward Zorinsky (D-NE), is the senior senator from Nebraska and serves as the ranking minority member, Senate Committee on Agriculture, Nutrition and Forestry. Senator Zorinsky will provide conference attendees with his insight into new agricultural programs and how they will effect agricultural production in years to come.

Senator David Durenberger (R-MN), member, Senate Finance Committee, Chairman of the Senate Intelligence Committee, and member of the Environment and Public Works Sub-committee. Senator Durenberger will address public policy impact on the business environment.

Senator Alan Dixon (D-IL), serves on the Senate Committee on Agriculture Nutrition and Forestry, Committee on Armed Services, Committee on Banking, Housing and Urban Affairs, and the Committee on Small Business. Senator Dixon, a strong supporter of fuel ethanol, will provide conference attendees with his view of ethanol's importance to our national energy security.

Congressman Edward Madigan (R-IL), serves as ranking minority Member of the House Committee on Agriculture and is third ranking Member of the House Committee on Energy and Commerce. He has represented the 15th Congressional District of Illinois since 1973, and is regarded as one of the most effective advocates for sound agricultural policies and programs in the U.S. Congress.

Congressman Kika de la Garza (D-TX) is Chairman of the House Agriculture Committee and has been instrumental in promoting legislation to protect and improve the farm economy through crop stabilization, expanded agricultural exports, and ethanol producer incentives.

Congressman Daniel Glickman (D-KS), a member of the House Committee on Agriculture and Committee on Science and Technology, is one of the original supporters of inaugural legislation for ethanol, has worked hard as a senior member of the Congressional Alcohol Fuels Caucus and is a leading supporter of a Strategic Alcohol Fuel Reserve.

CONFERENCE PROGRAM

TUESDAY, SEPTEMBER 30

8:00 a.m.–7:00 p.m. **Pre-Registration**
Pre-registration will be held throughout the entire day in the Capitol Hill Hyatt Regency in the escalator lobby on the ballroom level.

6:30 p.m.–8:00 p.m. **Welcome Reception**
An informal pre-conference gathering hosted by the Renewable Fuels Association and Information Resources, Inc. The Reception will be held in the Capitol Room located on the main lobby level.

WEDNESDAY, OCTOBER 1

7:00 a.m.–8:00 a.m. **Registration and Refreshments**
"Regency A" Ballroom level

8:00 a.m.–8:15 a.m. **Opening Remarks**
Mr. Eric Vaughn, President, Renewable Fuels Association

8:15 a.m.–8:35 a.m. **Keynote Address**
"Energy Challenges and U.S. Security" —Senator James McClure (R-ID), Chairman, Senate Committee on Energy and Natural Resources

8:35 a.m.–8:55 a.m. **"Public Policy Impact On The Market Place"**
Senator David Durenberger (R-MN), Member, Senate Finance Committee, Chairman, Environmental Oversight Sub-Committee, Chairman, Senate Intelligence Committee.

8:55 a.m.–9:15 a.m. **"Agriculture and its Potential for U.S. Energy Production"**
Congressman Edward Madigan (R-IL), Ranking Minority Member, House Committee on Agriculture and House Committee on Energy and Commerce

PANEL ONE

9:30 a.m.–10:45 a.m. **"Changes in Gasoline Marketing and New Market Trends"**
This panel of leading experts will provide the conference with the latest developments in gasoline marketing, analyze changing markets and discuss the impact new gasolines are having on the performance of automobiles.

Session Chairman—Mr. Art Stuckel, President of Pekin Energy Company and Chairman of the Board, Renewable Fuels Association

"World Crude Oil & U.S. Energy Security" —Dr. Charles Ebinger, Director of Energy and Strategic Studies, Georgetown Center for Strategic and International Studies.

"Gasoline Quality—How It Has Been and Needs to Be Improved" —Mr. Joe Colucci, Department Head, Fuels and Lubricants Department, General Motors Corp.

"Analyzing Changes in U.S. Octane Demand, Future Supplies and Prices"—Mr. Brad Van Tassel, Manager, Octane Components, The Pace Company

"New Developments in Ethanol/Gasoline Marketing" —Mr. Robert Reynolds, Manager, Strategic Planning, New Energy Co. of Indiana

10:45 a.m.–11:15 a.m. **Refreshments**
A full half-hour has been set aside for attendees to talk with panelists and other conference guests.

PANEL TWO

11:15 a.m.–12:30 p.m. **"Gasoline Composition, New Detergents and Additives"**
We have chosen top executives from leading petroleum organizations and chemical companies to discuss in detail the technical and market factors driving the rapidly changing grade mix and composition of America's motor fuels.

Session Chairman—Mr. Herb Bruch, Technical Director, National Petroleum Refiners Association

"Ultra 93 Octane" —Joint Presentation—Dr. Brian Davis, Senior Scientist, and George Crow, Manager of Fuels Planning and Economics, Sun Oil Company

"Texaco's Petrox Detergent Package" —Dr. Peter Dorn, Technologist, Texaco USA

"Chevron Gasoline with Techron" —Mr. Ron Koskie, Manager of Fuels and Lubricants and Mr. Richard J. Pevla, Senior Research Engineer, Chevron Research Company

"DuPont's DMA-67Y Additive Package" —Dr. Perry Polss, Manager, Petroleum Additives Technical Services, DuPont Company

"Fuel Additives and Alcohol Blended Gasolines" —Mr. Keith Ball, Senior Product Manager, Petrolite Company

12:30 p.m.–2:00 p.m. **LUNCHEON SPEAKERS**
Mr. Dan Lundberg, the nation's premier gasoline analyst, and the world renown marketing and pricing expert, will address conference attendees on the "Changing World of Gasoline Marketing." Mr. C. Boyden Gray, Counsel to Vice President George Bush and Chairman of the White House Task Force on Alcohol Fuels, will provide an overview of the Washington public policy agenda for alcohol fuels.

PANEL THREE

2:00 p.m.–3:15 p.m. **"Profit Improvement with Ethanol, MTBE and Methanol"**
With crude oil prices changing as rapidly as ever before, new corporate strategies are placing renewed pressure on the refining and marketing divisions of the majors. This panel will present profit improvement possibilities with the use of oxygenates.

Session Chairman—Mr. Kent Mittelberg, Vice President, General Manager, A.E. Staley Manufacturing Company

"Ethanol and the Gasoline Marketer" —Mr. Jim Bruce-Smith, President, Ethanol Corporation

"MTBE and the Refiner" —Mr. Bill Ludlow, Vice President, Oxygenates, DeWitt & Company.

"Methanol: Low Cost Octane Additive" —Mr. James Crocco, President, Crocco & Associates

"Refiner-Marketer Margins with Ethanol" —Mr. Ron Miller, Vice President, Marketing, Pekin Energy Co.

3:15 p.m.–3:45 p.m. **Refreshments**

CONFERENCE PROGRAM

Mr. J. Craig Potter, EPA's Assistant Administrator for Air Quality, will analyze EPA's regulatory agenda for motor fuels.

PANEL FOUR

3:45 p.m.–5:00 p.m.—**"Motor Fuel Regulations and EPA Fuel Waivers"**
With the emergence of new fuels and additives, regulatory considerations are becoming increasingly important to both suppliers and marketers. This panel will provide the conference with up to the minute definitions of new regulations and analyze their impact on a changing marketplace.

Session Chairman—Mr. George Unzelman, President, HyOx Corporation.

EPA's Air Quality and Motor Fuel Agenda for the 80's—Mr. J. Craig Potter, Assistant Administrator for Air & Radiation, U.S. Environmental Protection Agency will provide attendees with the future direction of EPA's policies.

Insight on the DuPont Waiver and Alcohol Fuels Policy at the Department of Energy—Mr. David Lindahl, Director, Office of Alcohol Fuels, U.S. Department of Energy.

Federal & State Regulatory and Tax Update: New Guidelines and Regulations"—Mr. James E. Peeples, Esq., Director of Legislative and Regulatory Affairs, Information Resources, Inc.

5:30 p.m.–7:30 p.m. **EVENING RECEPTION**—The Capitol Hill Hyatt Regency has been chosen for the evening reception. This elegant setting will allow conference attendees to speak with congressional representatives and key staff members about the various issues facing the alcohol and petroleum industries. The reception is sponsored by the Renewable Fuels Association and Information Resources, Inc.

Register Today
1-800-USA-FUEL

THURSDAY, OCTOBER 2

7:30 a.m.–8:15 a.m. **Refreshments**

8:15 a.m.–8:30 a.m. **Opening Remarks**
Mr. Todd Sneller, Executive Director, Nebraska Gasohol Commission.

8:30 a.m.–9:30 a.m. **Keynote Addresses**

8:30 a.m.–8:50 a.m. Senator Edward Zorinsky (D-NE), Ranking Minority Member, Senate Agriculture Committee and Senator Foreign Relations Committee.

8:50 a.m.–9:10 a.m. Congressman Dan Glickman (D-KS), House Committee on Agriculture, Committee Science and Technology.

9:10 a.m.–9:30 a.m. Senator Alan Dixon (D-IL), Senate Committees on Agriculture, Armed Services, Banking and Small Business.

PANEL FIVE

9:30 a.m.–10:30 a.m. **"International Trade and Alcohol Developments"**
International trade developments are having an increasingly important impact on the U.S. petroleum and fuel alcohol industries. The conference panelists will provide attendees with the latest trade developments and indicate the impact foreign operations are having on the U.S. industries.

Session Chairman—Mr. Donald Evans, President, New Energy Company of Indiana.

"CBI"—Mr. Rolando Perez, Vice President Sugar Division, EF Hutton Company.

"Europe"—Mr. Jean-Pierre LeRoudier, Secretaire General, Societe Franciase d'Expansion Commerciale et Industrielle.

"Brazil"—A senior Brazilian government official has been invited.

10:30 a.m.–11:00 a.m. **Refreshments**
A full half-hour has been set aside for conference attendees to visit with panelists and other conference guests.

PANEL SIX

11:00 a.m.–12:25 p.m. **"New Automotive & Fuel Technology Advances"**
New technological advances will have a lasting impact on the fuel and automotive sectors of the American economy. This panel will provide attendees with an overview of key changes that will effect energy consumption and production in the near-to-long term.

Session Chairman—Mr. Lauren Hill, General Manager, South Point Ethanol.

"Alternative Fuel Vehicle Technology"—Mr. Harry Buchanan, Senior Vice President, Celanese Corporation and Chairman of the Oxygenated Fuels Association.

"Improvements in Ethanol Process Technology"—Mr. Dick Gadomski, President, Process Systems Incorporated.

"New Sugar and Starch Conversion Technology"—Mr. Alan Metcalfe, Managing Director Queensland Science and Technology, President, BioCom International.

"Biomass Technology"—Mr. Joe Roetheli, Chief, Biomass Branch, Tennessee Valley Authority.

July 11, 1986

ANNOUNCING THE 1986 NATIONAL CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES

"Changing Gasoline Composition and New Market Trends"

Dear Executive:

If your professional responsibilities demand that you stay abreast of critical developments in gasoline refining and marketing, new venture planning and analysis, or environmental and regulatory policy, then this important conference is for you! Headlined by an impressive list of top level policy makers including: Senator James McClure, Chairman of the powerful Senate Energy and Natural Resources Committee; Senator David Durenberger, Member Senate Finance Committee; Congressman de la Garza, Chairman of the House Agriculture Committee; Congressman Edward Madigan, Ranking Minority Member, House Committee on Agriculture and House Committee on Energy and Commerce and Craig Potter, Assistant Administrator for Air & Radiation, U.S. Environmental Protection Agency. In addition Dan Lundberg, the nation's premier gasoline analyst and world renown marketing and pricing expert, will address conference attendees on the "Changing World of Gasoline Marketing" during a special luncheon presentation.

The timing of this conference is especially pertinent in light of the many changes that are occurring in the petroleum industry. The *1986 National Conference on Fuel Ethanol and Gasoline Additives* promises to provide you with the most comprehensive information available regarding critical developments in gasoline refining and marketing: new fuel detergent additives, refiner octane options, prospective Rvp controls, on-board vehicle controls, suboctane gasoline, and expected federal legislative and regulatory actions which may change the way we all do business. Conference attendees will gain valuable insight into the changing environment that alcohol, petroleum and automotive industry executives will likely face during the coming years.

As the conference program indicates, the Renewable Fuels Association's annual fall conference will feature top corporate executives from the nation's leading petroleum, automotive and fuel alcohol companies, including Sun, Chevron, Texaco, DuPont, General Motors, and many others.

Conference attendees will come away from the two-day session with an in-depth understanding of the current public policy challenges and market place developments that shape America's business environment.

In short, the *1986 National Conference on Fuel Ethanol and Gasoline Additives* will provide every conference participant with the understanding required to make intelligent choices regarding the future course of their business. To ensure your participation in the most important event this fall in Washington, you need only to fill in and return the attached conference registration form, or call the conference "HOTLINE" at 1-800-USA-FUEL.

Sincerely yours,

Eric Vaughn

Eric Vaughn
President
Renewable Fuels Association

1986 NATIONAL CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES

ABOUT THE CONFERENCE

Dan Lundberg, a legend in the world of gasoline marketing, will keynote the luncheon address.

Companies Represented at the Conference:

Conference attendees representing Mobil, Exxon, Amoco, Sun Oil, Texaco, Koch, ARCO, Shell, A.E. Staley, Archer Daniels, Midland, Cargill, Brazil, CBI, Europe, Celanese, DuPont, Ford, GM, Chrysler, Citibank and hundreds of other companies will be participating. The pace of early registrations indicates that over 500 executives will attend the 1986 National Conference on Fuel Ethanol and Gasoline Additives.

Advertisements: If conference attendees would like to advertise in the conference notebook they should send 500 advertisements by September 20, 1986 to: THE 1986 CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES, 499 South Capitol St., SW, Suite 406, Washington, D.C. 20003. If you should need additional information call our toll free conference hotline at 1-800-USA-FUEL or (202) 554-0614.

Conference Registration: Mail the conference registration form or call 1-800-USA-FUEL TODAY!!!

Conference Fees: $495 before September 15, 1986 or $595 thereafter.

Conference Location: THE 1986 CONFERENCE ON FUEL ETHANOL AND GASOLINE ADDITIVES, will be held in the Hyatt Regency Washington-Capitol Hill, located at 400 New Jersey Avenue, NW, Washington, D.C. 20001 telephone (202) 737-1234.

Hotel Reservations: The Sheraton Grand Hotel, 525 New Jersey Avenue, N.W., Washington D.C. 20001, (located next to the Hyatt Regency Washington-Capitol Hill) is holding a block of rooms until September 1, 1986 at a special rate for conference attendees, call (202) 628-2100. There will be additional overflow rooms available at the Capitol Hill Quality Inn (202) 633-1616.

Cancellation Policy: All cancellations MUST be received in writing. Those postmarked September 15, 1986 or after will be subject to a service charge of $100. Registrants who fail to attend and do not cancel prior to the conference are liable for the entire registration fee. You may send a substitute.

Travel Arrangements: United Airlines is the Official Conference Carrier. United Airlines is offering a 40% discount off a normal coach fare with no restrictions or a 5% discount off any fare you qualify for, based on normal restrictions. Please call 1-800-521-4041 and give the conference account number 6096C.
*If travel or hotel assistance is needed please call 1-800-USA-FUEL. Our staff will be pleased to assist you.

Conference Registration Form

Name _____

Title _____ Phone (____)_____

Company _____

Address _____

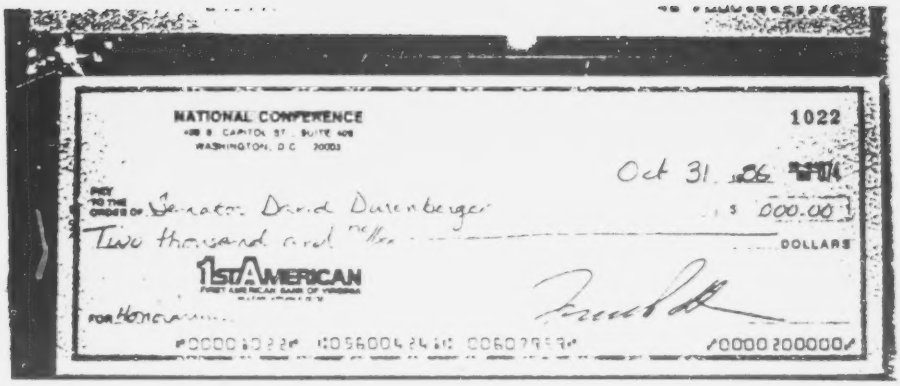
City _____ State _____ Zip _____

Registrant's Signature _____

Check appropriate box:
- ☐ Payment Enclosed (Check payable to 1986 National Conference)
- ☐ Bill Me Directly
- ☐ Bill Company (Payment Due Prior to Conference)
- ☐ I Would Like More Information

K

Note: Save $100 by paying *before* September 15, 1986. ($495 prior to 9/15/86, $595 thereafter.)



NATIONAL CONFERENCE
400 B CAPITOL ST., SUITE 405
WASHINGTON, D.C. 20003

1022

Oct 31, 06

PAY TO THE ORDER OF Senator David Durenberger $ 000.00

Two thousand and no/100 DOLLARS

1st AMERICAN
FIRST AMERICAN BANK OF VIRGINIA

FOR Honoraria

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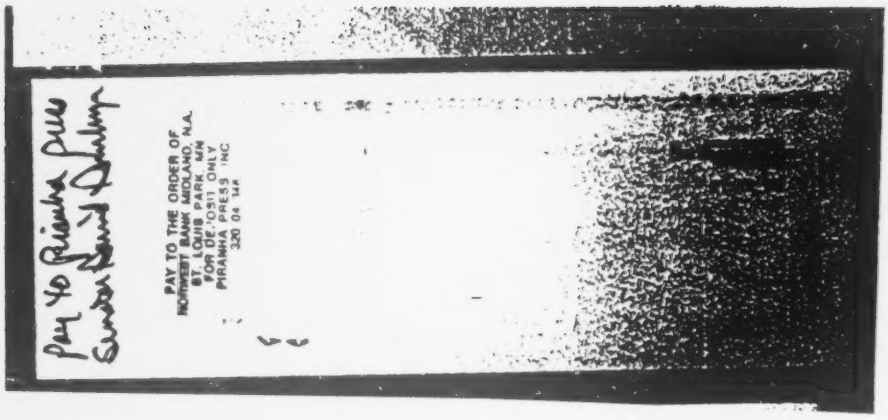

Pay to Pirania Pure
Sundar Rami Dudum
PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK MN
FOR DEPOSIT ONLY
PIRANHA PETS INC
320 04 1M4

Member of the New York Stock Exchange, Inc.
One New York Plaza
New York, N.Y. 10004 (212) 747-7000

Salomon Brothers Inc

March 12, 1985

The Honorable David F. Durenberger
United States Senate
Russell Senate Office Building 375
Washington, D.C. 20510
Attention: Ann Kelly

Dear Dave:

[redacted] Salomon Brothers Inc will hold its Second Annual Prepaid Health Care Conference. We would be honored if you would be our [redacted]

Salomon Brothers Inc is an investment bank [redacted] that serves the financing needs of health care providers, as well as other industries. In recent years, Salomon Brothers Inc has come to believe that prepayment for health care will play an increasing role in American health care because of its unique cost saving attributes. We sponsor this conference for interested institutional investment managers, and hospital and health plan administrators. Because of your keen awareness of health care issues and your central role in shaping Federal policy, we believe that your remarks would be most valuable to our understanding of the issues.

We understand that your schedule is extraordinarily full so we propose to make your visit as productive to you as possible. If you accepted, we would be delighted to arrange meetings with ratings agencies to learn their perspective on health care capital cost issues. Dr. Henry Kaufman, the Head of our Research Department would be honored to share his thoughts on the impact of the budget on his interest rate projections. Members of our Health Care Financing Group would also be available to discuss the financing needs and capacities of not-for-profit and investor owned health care companies. Naturally, we would also [redacted]

Thank you for your consideration.

Sincerely,

[redacted]

Douglas B. Sherlock, CFA
Vice President

DBS:tm

SPECIAL
COUNSEL
HEARING
EX. 189

A

REVISED

Salomon Brothers Inc

TO: Research Sales

FROM: John Stimpson JJS

DATE: March 22, 1985

SUBJECT: SECOND ANNUAL PREPAID HEALTH CARE CONFERENCE

Doug Sherlock will host his Second Annual Prepaid Health Care Conference on Monday, May 13, at the Plaza Hotel, from 8:00 AM through 5:30 PM, followed by cocktails. Representatives from the following companies are expected to give presentations:

Hospital Corporation of America
American Medical International
Health Care Systems and Services Group
Humana
Maxicare Health Plans
Safeguard Health Enterprises
United Health Care Systems
Prudential Health Care Plan
CIGNA Health Plan

(TENTATIVE) Keynote Speaker: Senator David Durenberger (R-MN) Chairman Health Subcommittee, Senate Finance Committee

Formal invitations will be mailed from the New York office. Please submit a typed client invitation list, including addresses, to Caryn Casino before Monday, April 1. Please include anyone you feel would have an interest in attending. We hope to match last year's large attendance.

B

Member of the New York Stock Exchange Inc

One New York Plaza
New York, N.Y. 10004 (212) 747-7000

Salomon Brothers Inc

March 22, 1985

Dear :

Thank you again for your willingness to speak at our Prepaid Health Care Conference on May 13th. As you can see, we have an outstanding group of speakers on that day. The conference will be held at the Plaza Hotel, 768 5th Avenue (at 59th Street) at the times shown below.

Based on responses from each of the conferees, the following appears to fit into everyone's schedules. It also clusters similar companies.

9:00 a.m.	Dr. Thomas F. Frist, Jr. MD, President and CEO Hospital Corporation of America
9:40 a.m.	American Medical International No speaker yet named.
10:20 a.m.	Break
10:35 a.m.	William Piche, President Health Care Systems and Services Group
11:15 a.m.	David A. Jones, Chairman of the Board and CEO Humana Inc.
Luncheon	Key Note Speaker: Senator David Durenberger (R-MN) Chairman Health Subcommittee, Senate Finance Committee (Tentative)
1:30 p.m.	Dr. Fred W. Wasserman, DPH, President and CEO Maxicare Health Plans, Inc.

C

Salomon Brothers Inc

2:10 p.m.	Safeguard Health Enterprises No speaker yet named.
2:50 p.m.	Jeffrey Weiner, Executive Vice President Will Skillman, Executive Vice President United States Health Care Systems
3:30 p.m.	Break
3:45 p.m.	Samuel H. Havens, President Prudential Health Care Plan
4:25 p.m.	Bradley C. Arms, Sr. Vice President and Chief Financial Officer CIGNA Health Plan Inc.
5:05 p.m.	Closing Remarks
5:30 p.m.	Reception
~~6:15 p.m.~~	~~Dinner~~

Again, we are honored that you all could come and speak at the Second Annual Salomon Brothers Inc Prepaid Health Care Conference. Should you have any questions or suggestions, please do not hesitate to give me a call.

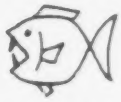
Sincerely,

Douglas B. Sherlock, CFA
Vice President

DBS:tm

D

PIRANHA



PRESS

Gary L. Diamond
Publisher

March 29, 1985

Mr. Douglas B. Sherlock
Vice President
Salomon Brothers, Inc.
1 New York Plaza
New York, NY 10004

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Sherlock:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before your organization in the near future.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book, Neither Madmen Nor Messiahs, and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book. It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

Because Senator Durenberger's appearance before your organization will be in promotion of Neither Madmen Nor Messiahs, we expect that you will make available to us adequate space at or near the

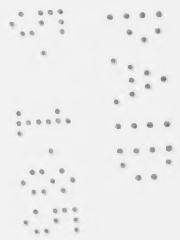
entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President



F

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
Monday, May 13	12:00 p.m.	New York City, NY	$5,000

G

PIRANHA 1 May 1985

PRESS

Gary L. Diamond
Publisher

As per your request, enclos are Senator Durenberger's airline tickets.

March 29, 1985

Mr. Douglas B. Sherlock
Vice President
Salomon Brothers, Inc.
1 New York Plaza
New York, NY 10004

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Sherlock:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before your organization in the near future.

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Because Senator Durenberger's appearance before your organization will be in promotion of Neither Madmen Nor Messiahs, we expect that you will make available to us adequate space at or near the

4504 EXCELSIOR BLVD · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

H

entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book. We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
Monday, May 13	12:00 p.m.	New York City, NY	$5,000

Tanya Martin
212/747-6232

[redacted]
New York, N.Y. 10004 (212) 747-7000

Salomon Brothers Inc

April 8, 1985

The Honorable David F. Durenberger
United States Senate
Russell Senate Office Building 375
Washington, D.C. 20510
Attention: Ann Kelly

Dear Dave:

We are delighted that you could come to speak at our Health Care Conference. I have always found your remarks extremely well considered and thought provoking.

As the keynote speaker, your speech should begin during the luncheon, which is scheduled for noon. The conference will be held at the Plaza Hotel in New York City on Fifth Avenue at 59th street on May 13. Our audience is particularly interested in Federal initiatives to encourage prepaid health plans including changes in the Medicare payment system and the partial taxation of health benefits. Since much of the audience will be interested in the hospital industry as well, your thoughts on the care of the indigent population, the Medicare reimbursement principles for capital costs and various hospital tax issues will also be valuable. Finally, as financial people, the audience will be interested in your thoughts on the progress of the budget.

As we indicated in our letter inviting you to speak, we would be pleased to arrange meetings for you with health care investment bankers, various ratings agencies and our economist Dr. Henry Kaufman. If these meetings are of interest to you please let us know at your earliest convenience.

→ we pt them to?

Again, we are honored that you could speak at our conference.

Sincerely,

Douglas B. Sherlock, CFA
Vice President

DBS:tm

cc: JP, CK

To: Accounts Payable Department

Date: 15 APRIL 1985

From: DOUGLAS SHERLOCK 12939

Department: STOCK RESEARCH 2022

PLEASE DRAW A CHECK

Payable To: ~~SENATOR DAVE DURENBERGER~~ PLASMA PRESS
4754 EXCELSIOR BLVD MINNEAPOLIS, MINN. 55416

Amount: FIVE THOUSAND & 00/100 (Please Print) $5,000.00

Purpose: HONORARIUM FOR KEYNOTE SPEAKER AT PREPAID HEALTH CARE CONFERENCE ON MAY 13TH. STOCK RESEARCH & CORP. FIN. WILL GO 50/50 ON THE EXPENSE.

Charge to if Other Than Person Requesting Check

Employee Name: STEVE GRANDJEAN — Number: 05114

Department Name: CORPORATE FINANCE — Number: 12200

Disposition of Check: PLEASE CALL X6132 (DOUG SHERLOCK'S OFC) WHEN CHECK IS READY. Send Federal Express

Approved By:

(For Accounts Payable Use Only)

ACCOUNTS PAYABLE VOUCHER

NV

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CONTROL TOTAL

FINAL TOTAL 500000

Special Instructions

Date

Next Page

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To: Accounts Payable Department

Date: 15 APRIL 1985

From: DOUGLAS SHERLOCK 1 2 9 3 9

Department: STOCK RESEARCH 2 0 2 2

PLEASE DRAW A CHECK

Payable To: ~~SENATOR DALE BUMPERS~~ PIRANHA PRESS

04643

Invoice Number/Date	Entry Date	Description	Gross Amount	Discount	Net Amount
Check No.		Totals			

Salomon Brothers Inc
Member of the New York Stock Exchange
One New York Plaza/New York, N.Y. 10004

04643

Pay to the Order of | Date | Check Number | Amount

PIRANHA PRESS | MAY 1 85 | 4643 | [redacted] | 5000.00

NON NEGOTIABLE

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To Chase Manhattan Bank, N.A.
New York, N.Y.

Authorized Signature

2nd

CONTROL TOTAL 5000.00

FINAL TOTAL

Special Instructions

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Approval

Date

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Next Page

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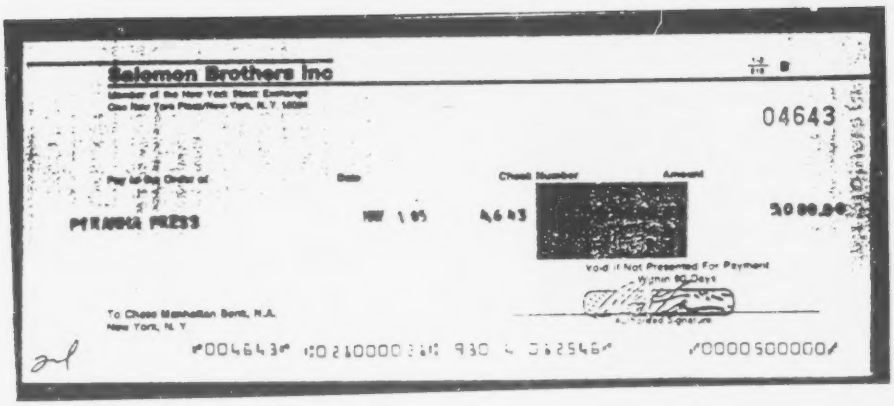
Salomon Brothers Inc

Member of the New York Stock Exchange
One New York Plaza/New York, N.Y. 10004

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Date

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4643

Amount

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Authorized Signature

To Chase Manhattan Bank, N.A.
New York, N.Y.

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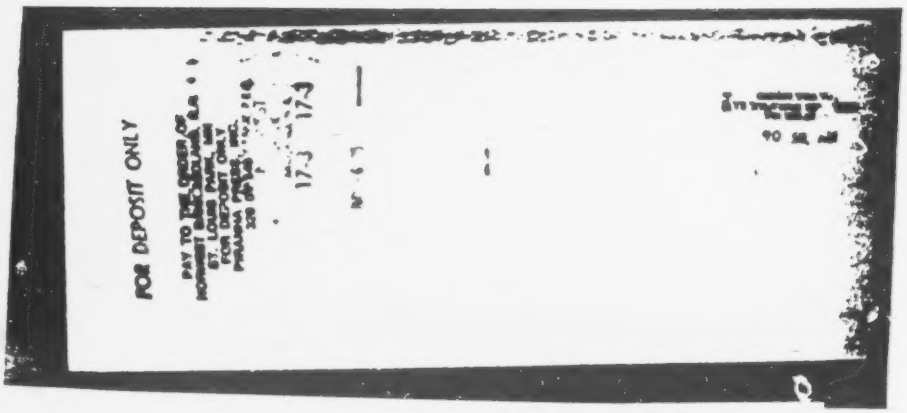
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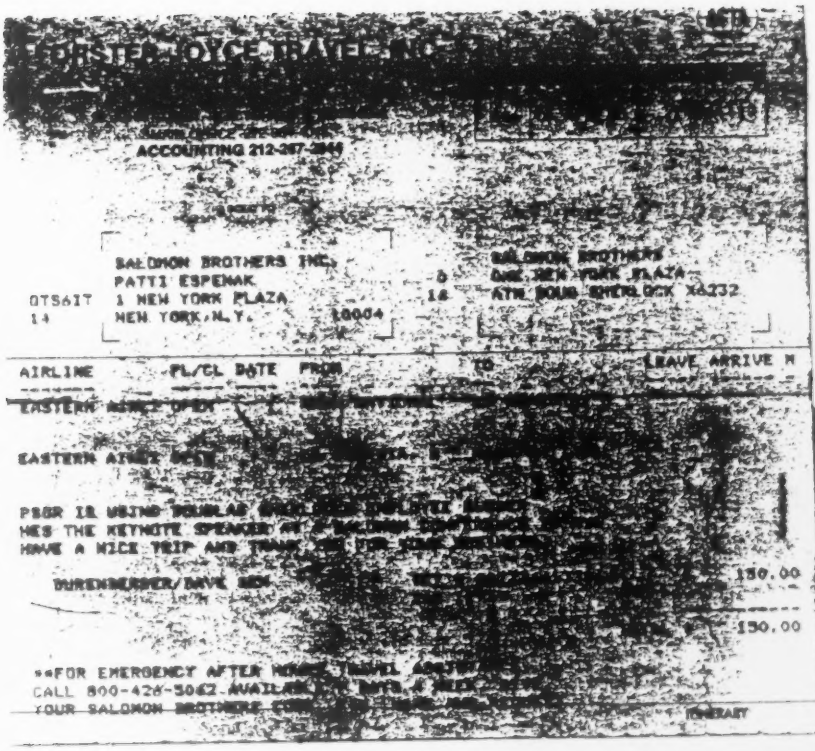

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OTS&IT 1 NEW YORK PLAZA
14 NEW YORK,N.Y. 10004

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ONE NEW YORK PLAZA
ATTN ROUB SHERLOCK X6232

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EASTERN AIRLINES DESK

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HAVE A NICE TRIP AND THANK

DURENBERGER/DAVE MCK

150.00

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CALL 800-426-3062 AVAILABLE
YOUR SALOMON BROTHERS

ITINERARY

RSVP on 2/9/86 3/4

SECURITIES INDUSTRY ASSOCIATION
1111 Nineteenth Street, N.W. Washington, D.C. 20036 (202) 296-9410

January 22, 1986

The Honorable Dave Durenberger
United States Senate
147 Senate Russell Office Building
Washington, DC 20510

Dear Senator Durenberger:

Over 100 senior executives of stock brokerage and investment banking firms who serve on SIA's Board of Directors and policy committees will meet in Washington March 3-5. I invite you to participate, with other members of the Finance Committee, in a panel discussing tax issues.

The securities industry is acutely sensitive to tax policy. We hope that the panel will inform the industry's leaders of the issues raised by pending tax legislation and the economic, fiscal, and political factors which will affect the Committee's consideration of the bill.

The panel will begin at 9:00 on Tuesday, March 4, at the L'Enfant Plaza Hotel. An honorarium of $2,000 is offered for this event. I will advise you of other panelists and the name of the meeting room when that information is available.

I hope your schedule will allow you to accept our invitation. Should you or your staff have any questions or need any information, please call me at 296-9410.

SPECIAL COUNSEL HEARING EX. 190

A

Best regards,

Stephan K. Small
Vice President and Director
of Congressional Relations

SKS:sm

NEW YORK OFFICE 120 Broadway New York N.Y. 10271 (212) 608-1500

TO: Mahoney/Tamara
FROM: Jodi/DD

1/3 '4

SECURITIES INDUSTRY ASSOCIATION
1111 Nineteenth Street, N. W. Washington, D. C. 20036 (202) 296-9410

Details:
*2K ok to Piranha
MM to call

January 22, 1986

Contact: Stephen Small
- he has questions on how they file the info. at the end of the year.

The Honorable Dave Durenberger
United States Senate
147 Senate Russell Office Building
Washington, DC 20510

Dear Senator Durenberger:

Over 100 senior executives of stock brokerage and investment banking firms who serve on SIA's Board of Directors and policy committees will meet in Washington March 3-5. I invite you to participate, with other members of the Finance Committee, in a panel discussing tax issues.

The securities industry is acutely sensitive to tax policy. We hope that the panel will inform the industry's leaders of the issues raised by pending tax legislation and the economic, fiscal, and political factors which will affect the Committee's consideration of the bill. - Broad topics

The panel will begin at 9:00 on Tuesday, March 4, at the L'Enfant Plaza Hotel. An honorarium of $2,000 is offered for this event. I will advise you of other panelists and the name of the meeting room when that information is available. 10/10: Ben

I hope your schedule will allow you to accept our invitation. Should you or your staff have any questions or need any information, please call me at 296-9410.

Best regards,

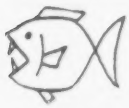
DD - Small thinks his group should know DD better
Moynihan has accepted (capital gains)
Bradley (reform fervor)
Roth BTT

Stephan K. Small
Vice President and Director
of Congressional Relations

SKS:sm

Taper Piper will attend
(he is a member of the Board's tax committee)

PIRANHA



PRESS

Gary L. Diamond
Publisher

MEMORANDUM

TO: Mr. Stephan K. Small
Securities Industry Association
1111 19th Street NW
Washington, DC 20036

FROM: PIRANHA PRESS

DATE: FEBRUARY 11, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

We wish to advise you that Senator Durenberger has entered into an exclusive arrangement with us under which we must consent to his appearance and agree to the fees and expenses for any such appearance. Under our arrangement, you will be contacted by the law firm which represents Senator Durenberger for purposes of clarifying this arrangement and the fees to be paid.

If you have any questions, please contact Senator Durenberger's office or Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.
Kitty Gamble
Jodi Mathison

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

PIRANHA

PRESS

Gary L. Diamond
Publisher

February 14, 1986

Mr. Stephan K. Small
Vice President and Director
Securities Industry Association
1111 19th Street NW
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Small:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Securities Industry Association on March 4, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

The [illegible] of the sums due us must be [illegible] within ten days from the date of this letter.

Mr. Stephan K. Small
Vice President and Director
Securities Industry Association
February 14, 1986
Page 2

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

E

APPEARANCE SCHEDULE

Date	Place	Amount
March 4, 1986	Washington, DC	$2,000

F

PLEASE PROCESS UPON RECEIPT.

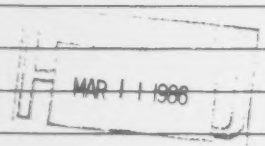
SECURITIES INDUSTRY ASSOCIATION

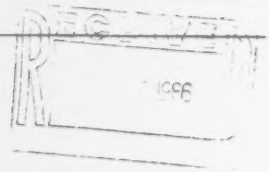
CHECK REQUEST FORM

PAYEE: Piranha Press AMOUNT: $ 2,000

ADDRESS: 4504 Excelsior Blvd.
Minneapolis, MN 55416
Attn: Gary Diamond, President

Payment in lieu of honorarium for Sen. Dave Durenberger for speaking at the Government Relations Meeting, March 4, 1986.





DATE: 3/5/86 REQUESTED BY:

DATE: 3/6/86 APPROVED BY:

G

Securities Industry Association 1424

March 10, 19 86 5-20/110

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Boston, Massachusetts
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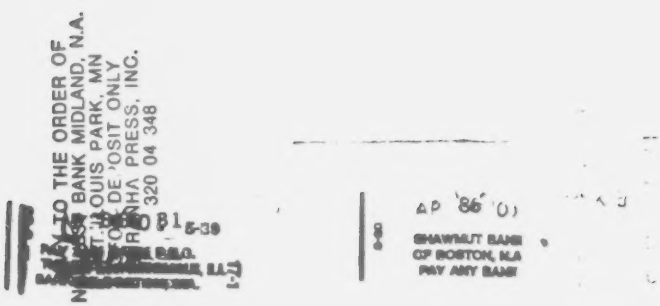
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LOUIS PARK, MN
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AP '86 01
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OF BOSTON, N.A
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SECURITIES INDUSTRY ASSOCIATION
1111 Nineteenth Street, N.W. Washington, D.C. 20036 · (202) 296-9410

March 27, 1986

Mr. Gary L. Diamond
Publisher
Piranha Press
4504 Excelsior Boulevard
Minneapolis, MN 55416

Dear Mr. Diamond:

Senator Dave Durenberger's participation at our annual Government Relations Meeting on March 4 was superb. He added a great deal to our program, and our members thoroughly enjoyed his comments.

In accordance with our understanding, please find enclosed a check for $2,000 offered by SIA in lieu of a honorarium. That check has finally been signed and forwarded to us, and we apologize for the delay.

Thank you again for your assistance in helping to arrange for Senator Durenberger's appearance.

Sincerely,

Stephan K. Small
Vice President and Director
of Congressional Relations

SKS:sm

Enclosure

NEW YORK OFFICE 120 Broadway New York, N.Y. 10271 · (212) 608-1500

PRE-APPOINTMENT INFORMATION

EVENT DATE: 2/27 eve TH

TODAY'S DATE 1/30/85

CONTACT: David Metzner

TELEPHONE: 553-6310

APPOINTMENT WITH: DD STAFF: Speak

FOR: Singer Company

TITLE: ($2 billion company)

COMPANY:

ISSUE: $1K honorarium

NUMBER OF PEOPLE: 20 top level mgmt

ADDITIONAL NAMES:

PAC cmtes steering cmte (all exec. vice presidents)

They have $100K to give out. Want DD to discuss role of PACs in America

NOTES:

They'd like DD to speak 2 Enfant Plaza about 8:15 (after the dinner) → conflict "Up With People" w/ Honeysuckle.

SPECIAL COUNSEL HEARING EX. 191

A

file in 3/4
2/27
day file

TO: Senator

FROM: TH

RE: Speech to Singer PAC

DATE: Feb. 26, 1985

You will be speaking Wednesday to the Singer PAC. The speech will be following dinner and will be to a relatively small group (about 30 people). Therefore, the speech is informal.

You are scheduled to be the only speaker at dinner. The dinner is the kick-off of the Singer PAC planning session which extends all day Thursday. On Thursday, the PAC heads will begin making decisions on the 1986 races. They do have two congressional speakers Thursday (breakfast and lunch): Dave McCurdy (Dem. of Okla.) and Ed Zschau (Rep. of Calif.).

The Singer PAC steering committee--your audience--is comprised mostly of the marketing vice presidents of Singer from around the country. These are top-level management people and will include representatives of Singer's Washington office (David Metzner, the Washington rep.).

Singer's business is now about one-half aerospace (mostly government, some commercial--e.g., flight simulators for airlines) and one-half consumer goods.

The PAC is about one year old. They hope to have these steering committee strategy sessions about every three to four months.

Your role will be to discuss the importance/value of PACs. Your boilerplate language from your Rules Committee testimony (attached) is appropriate.

In addition, you need to urge PACs to be a little more daring--they have to start funding challengers, especially in those cases where the incumbent does not agree with the PAC's philosophy.

In 1986, business PACs had better decide how much they care about the country's business climate, the rate of inflation, interest rates, etc., and decide which party is going to do a better job of resolving those problems.

B

Singer PAC
Page 2

You also need to put in a good word for the GOP's chances to keep the Senate majority in 1986. There are 22 incumbent Republican seats up for re-election (only 12 Democrats) and only Goldwater has said he will not run. On the other hand, Eagleton and Long are not running and good Republican candidates are in the wings (including Kit Bond and Henson Moore); Hart may not run for the Senate, concentrating on 1988 instead; Leahy and Cranston are vulnerable.

Defending 22 Republican seats (16 of which are held by first-termers) will be difficult. But, the prospects of holding the Senate majority are much brighter today than they were just a few months ago.

C

Date

Ms. Ann Kelly
353 Russell, Senate Office BUilding
Washington, D.C. 20515

RE: SPEAKING ENGAGEMENTS

Dear Ms. Kelly:

Pursuant to Senator Durenberger's agreement with Piranha Press, we hereby confirm that the Senator will speak to the Singer Company on February 27, 1985.

After you receive this telegram, please contact Susan Anderson (612) 333-5411 and confirm this speaking engagement.

Very truly yours,

SUSAN K. ANDERSON
Legal Assistant

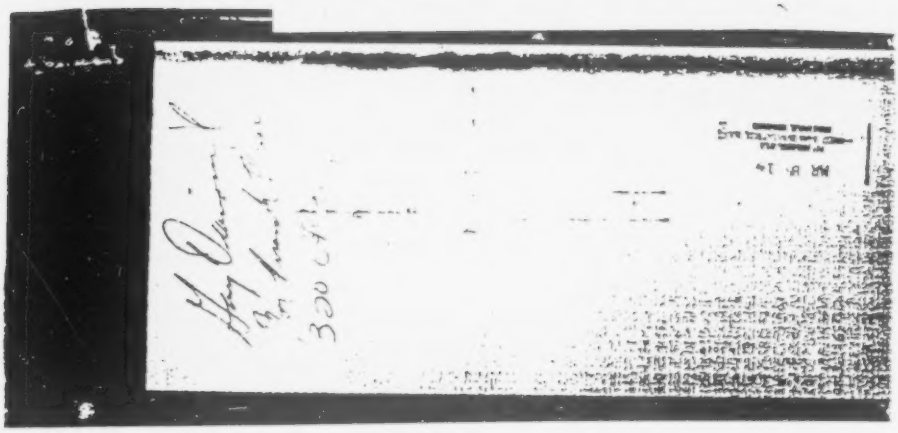
confirmed by phone 2/25

Fourth weekly schedule

2 p chart + feed Subject

D

SINGER
02/25/85
$1,000.00
ONE THOUSAND AND 00/100 DOLLARS



People on this page names only

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~~September 1, 1985~~

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Director
Industrial Relations Section
Princeton University
Princeton, NJ 08544
(609) 452-4045

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Dean
School of Industrial Administration
Carnegie-Mellon University
Pittsburgh, PA 15213

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943 Hayne Road
Hillsborough, CA 94010
(415) 343-3085

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Chairman
3000 Sand Hill Road
Building 4, Suite 180
Menlo Park, CA 94025
(415) 854-3000

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2219 Fir Lane
Mitchell Point
Friday Harbor, WA 98250

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Hewlett-Packard Co.
1501 Page Mill Road
Palo Alto, CA 94304
(415) 857-2626

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Bank of America Center
P.O. Box 37000
San Francisco, CA 94137
(415) 622-6092

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10132 Hillgrove Drive
Beverly Hills, CA 90210
(213) 275-5791

Mr. and Mrs. Franklin P. Johnson, Jr.
Asset Management Company
1411 Edgewood Drive
Palo Alto, CA 94301
(415) 321-3131

Mr. Andrew Knight
Editor, The Economist
The Economist Building
25 Saint James's Street
London SW1A 1HG, ENGLAND
(01) 839-7000

Mr. and Mrs. Edmund W. Littlefield
550 California Street
San Francisco, CA 94104
(415) 981-1515; 348-1166

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185 East Dana Street
Mountain View, CA 94041
(415) 969-1310

Mr. and Mrs. Arjay Miller
225 Mountain Home Road
Woodside, CA 94062
(415) 851-1217; 497-9128

Dr. and Mrs. William J. Perry
10701 Mora Drive
Los Altos, CA 94022
(415) 986-5500 ext. 452

Mr. and Mrs. P. Anthony Ridder
San Jose Mercury News
750 Ridder Park Drive
San Jose, CA 95131
(408) 920-5000

SPECIAL COUNSEL HEARING EX. 192

A

Emeriti

Mr. Kenneth W. Dam
IBM Corporation
Old Orchard Road
Armonk, NY 10504

The Honorable George P. Shultz
Secretary of State
2201 C Street, N.W.
Washington, D.C. 20520

Provost and Mrs. James N. Rosse

Address as indicated (don't add spouses if not there already from here on.)

ASSOCIATES

Dr. Bernard S. Aarons
752 Middlefield Road
Palo Alto, CA 94301

Mr. and Mrs. Vernon R. Anderson
25225 La Loma Drive
Los Altos Hills, CA 94022
(415) 960-1980

Dr. William E. Ayer
3000 Sand Hill Road
Building 4, Suite 170
Menlo Park, CA 94025

Mr. and Mrs. Peter B. Bedford
Bedford Properties
P.O. Box 1267
Lafayette, CA 94549
(415) 283-8262

Dr. and Mrs. Peter S. Bing
9700 West Pico Blvd.
Los Angeles, CA 90035
(213) 277-3222

Mr. John M. Black, Jr.
General Manager - Central California
Pacific Telephone Company
2 North Second Street
San Jose, CA 95113
(408) 491-1555

Mr. John B. Boatwright
Corporate Planning Department
Exxon Company, U.S.A.
P.O. Box 2180
Houston, TX 77001
(713) 656-1693

Mr. and Mrs. Preston Butcher
1 Robert S. Drive
Menlo Park, CA 94025

Dr. Richard Call, President
The Seaver Institute
900 Wilshire Blvd.
Los Angeles, CA 90017
(213) 688-7550; 6887621

Mr. Henry G. Cory, Director
University Rel. & Corp. Contributions
Conoco Inc.
High Ridge Park
Stamford, CT 06904

Mr. Thomas J. Davis
2200 Sand Hill Road
Suite 201
Menlo Park, CA 94025
(415) 854-5560

Mr. and Mrs. Reid W. Dennis
3000 Sand Hill Road
Suite 290, Building 2
Menlo Park, CA 94025
(415) 854-0132

Mr. Herbert M. Dwight, Jr.
Spectra-Physics
3333 North First Street
San Jose, CA 95134
(408) 946-6080

Mr. William C. Edwards
Bryan & Edwards
3000 Sand Hill Road
Building 2, Suite 260
Menlo Park, CA 94025
(415) 854-1555

Barbara 13.11

Mr. Donald F. Eldridge
175 Alta Vista
Atherton, CA 94025
(415) 854-6687; 854-4631

Dr. Anthony Finizza
Corporate Planning
Atlantic Richfield Company
515 South Flower Street
Los Angeles, CA 90071

Mr. Robert C. Fisher
Vice-President for Public Affairs
Saga Corporation
1 Saga Lane
Menlo Park, CA 94025

Mr. and Mrs. Thomas W. Ford
3000 Sand Hill Road
Building 4, Suite 180
Menlo Park, CA 94025
(415) 854-3000

(On Alumni Board)

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Koret Foundation
201 Filbert Street
Fifth Floor
San Francisco, CA 94133

Mr. and Mrs. Arthur Graham
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Redwood City, CA 94063
Free-Flow Packaging
1093 Charter Street
Redwood City, CA 94063
(415) 364-1145

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Greene, Radovsky, Maloney, & Share
1 Market Plaza
32nd Floor
San Francisco, CA 94105

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2200 Sand Hill Road
Menlo Park, CA 94025

Mr. Roger W. Heyns
President
The William & FLora Hewlett Found.
525 Middlefield Road
Menlo Park, CA 94025

Mr. Donald Hornekamp
Corporate Planning
Atlantic Richfield Company
515 South Flower Street
Los Angeles, CA 90071

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260 Maple Court
Ventura, CA 93003
(805)644-7116

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2125 Inglewood Avenue
St. Helena, CA 94574

Mr. Scott Jones
Corporate Planning
Atlantic Richfield Company
515 South Flower Street
Los Angeles, CA 90071

Dr. Walter Kenworthy
Exxon Education Foundation
111 West 49th Street
New York, New York 10020-1198
(212) 333-6327

Mr. Dennis B. King
King & Stocklin
2600 El Camino Real
Room 607
Palo Alto, CA 94306
857-0221

Mrs. Susan Koret
711 El Camino Del Mar
San Francisco, CA 94121

Mrs. Charles B. Kuhn
3745 Yerba Buena Road
San Jose, CA 95121
(408) 274-4916

Drs. Ralph and Claire Landau
Listowel, Inc.
2 Park Avenue
New York, N.Y. 10016
(212) 683-8660; (415) 327-3104

Mr. J. Frank Leach
3000 Sand Hill Road
Building II, Suite 140
Menlo Park, CA 94025
(415) 854-0147

Mr. Edmund W. Littlefield
Chairman, The Executive Committee
Utah International, Inc.
550 California Street
San Francisco, CA 94120
(415 981-1515; 348-1166

Mr. and Mrs. Frank J. Lodato
1472 Club View Drive
Los Altos, CA 94022
(415) 969-1310;948-7825

Mr. Donald L. Lucas
President
The Lucas Dealership Group
130 Center Plaza
San Jose, CA 95113

Mr. Charles Lynch yes Charlie
Chairman of the Board and
Chief Executive Officer
Saga Corporation
1 Saga Lane
Menlo Park, CA 94025

Mr. Dalton W. Martin yes
11275 Summitwood Road
Los Altos Hills, CA 94022
(415) 941-8787

Mr. and Mrs. Burton J. McMurtry
Technology Venture Investors
3000 Sand Hill Road
Building 4, Suite 210
Menlo Park, CA 94025 yes Burt

Mr. James E. McNabb
Manager
Economics and Policy Division
Conoco Inc.
1007 Market Street
Wilmington, DE 19898

Mr. A. A. Milligan no
Bank of A. Levy
P. O. Box 272
Oxnard, CA 93032

Mr. Kenneth A. Moline
Executive Vice President
Koret Foundation
201 Filbert Street, Fifth Floor
San Francisco, CA 94133
(415) 989-4650

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712 Blair Avenue
Piedmont, CA 94611

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4260 Virginia Beach Road
Long Beach, CA 90807

Mr. Charles Schwab, President no
Charles Schwab & Company
One Second Street
San Francisco, CA 94105
(415) 546-1000

Mr. Clint Smith yes
The William and Flora Hewlett Foundation
525 Middlefield Road, Suite 200
Menlo Park, CA 94025
(415) 329-1070 Clint Smith

Mr. Louis B. Sullivan
Corroon & Black
1530 The Alameda
Suite 100
San Jose, CA 95126
(408) 286-5151

Mr. Thaddeus N. Taube yes
Woodmont Companies
1050 Ralston Avenue
Belmont, CA 94002
(415) 592-3960

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Pacific Gas and Electric Co.
77 Beale Street
San Francisco, CA 94106

Ms. Mary Wohlford yes ?
2275 Broadway #624
San Francisco CA 94115
(415)931-0250

Mr. Robert Freedman
VP for Public Affairs
Stanford University
Stanford, CA 94305

Mr. Larry Horton
Assoc VP Public Affairs
Stanford University
Stanford, CA 94305

Provost James N. Rosse
Stanford University
Building 10
Stanford, CA 94305

1/31/86

January 6, 1986

TO: Senator Durenberger
Fr: Paul Hewitt
RE: Speech Invitation at Stanford

AGE Advisory Board member and nationally-renown economist Michael Boskin has invited you to address the Center for Economic Policy Research (CEPR) on generational equity at Stanford University on Friday, January 31. The audience will consist of about 75 top California business executives, mostly from Silicon Valley.

The occasion is the annual meeting of the CEPR Advisory Board, which is headed by Hewlett-Packard Chairman Bill Hewlett. CEPR was originally organized by George Schultz when he was at Bechtel. It is essentially an in-house research institute at the university.

You are invited to make the luncheon address (in lieu of Rudy Penner, who had to decline on account of Graham-Rudman). You are also invited to attend the workshop that morning, but that is optional. Boskin only insists that you meet Stanford President Donald Kennedy, who, if you are not already aware, is both a fan of yours and a public advocate for generational equity. (In fact, Boskin thinks Kennedy would be a good prospect for AGE's Board of Directors.)

I have negotiated a $10,000 honorarium, of which some portion could be donated to AGE, ala the steel lunch. Out of this would come your air transportation costs.

Boskin envisions that you would take a late-afternoon flight out of Washington on Thursday (United operates a direct connection out of Dulles at 5:30 p.m., which gets in about 9:30 p.m., as does TWA). His staff would pick you up and take you to Stanford's guest quarters, where you would spend the night. Again, you would not be formally scheduled for anything until lunch. During lunch you will have 30 minutes to speak and take questions from the floor.

Boskin has also needs: (1) to know if you would like any advance publicity for your speech (he will arrange to have reporters present) and if you have any West Coast friends you want to invite; and (2) your social security number and home address for administrative purposes. I gave him Jodi's name and told him she would contact him shortly.

This looks like an excellent opportunity to forge connections with key West Coast business leaders for AGE. I strongly urge you to accept this gracious invitation.

E

CENTER FOR
ECONOMIC POLICY
RESEARCH

STANFORD
UNIVERSITY

Drew

Carolyn Sherwood
415-329-1210

James L. Sweeney
Director
(415) 329-1218
Carolyn Sherwood
Assistant Director
(415) 329-1210
Jean Barnes
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(415) 329-1212

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January 9, 1986

Senator Dave Durenberger
United States Senate
154 Russell Senate Office Building
Washington, DC 20510

Dear Senator Durenberger:

We are delighted that you will be able to join us to deliver the John M. Olin Distinguished Lecture at the Annual Meeting of our Advisory Board and Associates. I am sure that the group will greatly enjoy hearing you speak on the subject of generational equity. I have much admired your work on various issues involved in this subject and look forward to the opportunity to renewing our acquaintance. The fund for the John M. Olin Distinguished Colloquium speaker has a budget of $10,000.00 to include honoraria and travel expenses. In addition to the above luncheon speech, we also hope that you will be able to spend some time Friday morning with students and university officials.

The luncheon is scheduled for Friday, January 31st, from 12:00 to 2:00 p.m. We will avoid scheduling anything early Friday morning so you should be free before 10:00 a.m. California time.

The Advisory Board and Associates of the Center for Economic Policy Research comprise some of the most prominent business people in Silicon Valley and San Francisco. They are knowledgeable and concerned citizens, and I am sure that they will find your talk lively and informative. We would also like to make the visit as convenient and as enjoyable for you as possible. If there are any friends or associates you would like to have invited to the luncheon, please notify Carolyn Sherwood at 415/329-1210. Also, we will forward to you a list of luncheon guests, together with their affiliations. My conjecture is that there will be somewhere between 60 and 100 persons in the audience. In addition to the general set of introductions over cocktails at the lunch hour, if there are any of these people in particular you would especially like to have seated at your table or a more extensive time for introductions, please let me know and I will do everything I can to arrange it.

100 Encina Commons, Stanford University, Stanford, California 94305 F (415) 329-1211

When your travel plans are finalized, you should have your staff phone Carolyn Sherwood at the number above. We will arrange local transportation and accommodations. Unless we hear otherwise, we will assume a late arrival on the night of January 30th and book you a room for that night. Will you be traveling with staff or family? Again, please let Carolyn know how many rooms she should reserve, and if you plan to stay longer than the one day. I know your time is very precious, but if you are able to extend your stay into the weekend, we would be delighted and pleased to put together social or other arrangements you desire. Also, if you arrive early evening California time Thursday night and if you wish to do so, there will be a dinner at the Meyer-Buck House, a special University facility, that night hosted by Advisory Board Chairman, Bill Hewlett. We would be pleased to have you join us for any or all of that occasion, but we understand that it may be difficult to be fitted into your travel schedule.

Finally, please have someone on your staff telephone Carolyn Sherwood with your social security number and home address, since these are needed by the University's accounting office in order to issue the check.

Let me say again how delighted I am that you are able to join us. We look forward with great anticipation to your address.

Best personal wishes.

Cordially,

Mike

Michael J. Boskin

MJB:rr

cc: Jim Sweeney, CEPR
Carolyn Sherwood, CEPR

P.S Additional copy sent regular mail

G

CENTER FOR
ECONOMIC POLICY
RESEARCH

STANFORD
UNIVERSITY

January 23, 1986

James L. Sweeney
Director
(415) 725-1871
Carolyn Sherwood
Assistant Director
(415) 725-1872
Deborah Drew
Administrator
(415) 725-1873

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The Honorable David Durenberger
United States Senate
154 Russell Building
Washington, DC 20510

Dear Senator Durenberger:

I understand that our staffs have been in contact on the logistics of your visit to Stanford. I am writing to fill you in on arrangements at this end.

Reservations have been made on January 30-31, for you and Paul Hewitt at the Stanford Park Hotel in Menlo Park, a short distance from the Stanford campus. The address is 100 El Camino Real and the phone number is (415) 322-1234. If you need transportation arrangements made, the CEPR staff can help.

There will be a dinner Thursday evening for the Board and faculty connected with the Center. We would be delighted to have you join us if you arrive early enough. I enclose invitations to both the dinner and the luncheon.

As a frequent flyer between here and Washington, I would like to pass on that it is virtually impossible to leave the Washington area in the morning and be sure of arriving in time for a noon engagement. The only direct flight arrives well after noon, and the alternative flights are quite often subject to long delays either on take-off or en route. It is rather important for you to fly in the evening before. I have not scheduled anything for the early morning in the event it is necessary for you to take a late flight.

I have arranged a meeting at 11:15 with Stanford's Vice President and Provost James N. Rosse who will be acting President in Donald Kennedy's absence. Also present will be Vice President for Public Affairs Robert Freelen and his Associate V. P. Larry Horton. They will accompany us to the luncheon at Saga Corporation. If possible, I would also like to arrange an earlier, informal meeting with students.

May I say, once again, that we are most pleased you can be with us and are looking forward to your talk. If you or your staff have any questions regarding any of these arrangements, please do not hesitate to call.

Best personal wishes,

Cordially,

Michael J. Boskin

MJB:cbs
Encl.

H

100 Encina Commons, Stanford University, Stanford, California 94305 (415) 725-1874

CHECK REQUEST - TYPE B

(FOR NONEMPLOYEE SERVICES, SUPPLEMENTAL RESEARCH SUPPORT, ETC.)

(NOT FOR ADVANCES OR REGISTRATION FEES)

CHECK REQUEST NO. 151387

ITMENT (INCLUDE BUILDING & ROOM NO. IF CHECK IS TO BE SENT TO DEPT.)	DATE CHECK WANTED	DATE OF REQUEST
ics Gen Economic Policy Research 100 Encina Commons	1/28/86	1/16/86

UNT NAME (OR CONTRACT OR GRANT NO.)

EPA 001

WILL PICK UP CHECK AT ACCOUNTS PAYABLE SECTION ENCINA HALL BASEMENT

MAIL CHECK TO: [X] DEPARTMENT SHOWN ABOVE [ ] PAYEE'S PERMANENT ADDRESS SHOWN BELOW [ ] THIS ADDRESS

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Complete appropriate section

PAYMENT TO NONEMPLOYEE OR ORGANIZATION FOR SERVICES

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PERIOD DURING WHICH SERVICES PERFORMED: January 1986

PURPOSE OF PAYMENT: Honorarium provided for Senator Durenberger's presentation to CEPR's Advisory Board

e.g., fees (but not registration fees), ees, licenses, honoraria, non Stanford tuition, tuition subject withholding

LEAVE BLANK

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e.g., refund of conference deposit

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BENEFICIARY'S DEPARTMENT (IF NOT SHOWN ABOVE)

ACCOUNT NO.	DRAW CHECK TO (PAYEE'S LAST NAME, FIRST NAME & INITIAL) (MAX = 23)	TYPE	PAYEE'S SOCIAL SECURITY NO.	AMOUNT
1 EPA 001 94690	Durenberger, David (Senator)	06	471-36-4210	$2000.00
1KEA001 N1632		06		7.50
1 5K1012 94601	↓	07		(7.50)

EMARKS

Note: See CRB 151356 for org. information - 1/16/86

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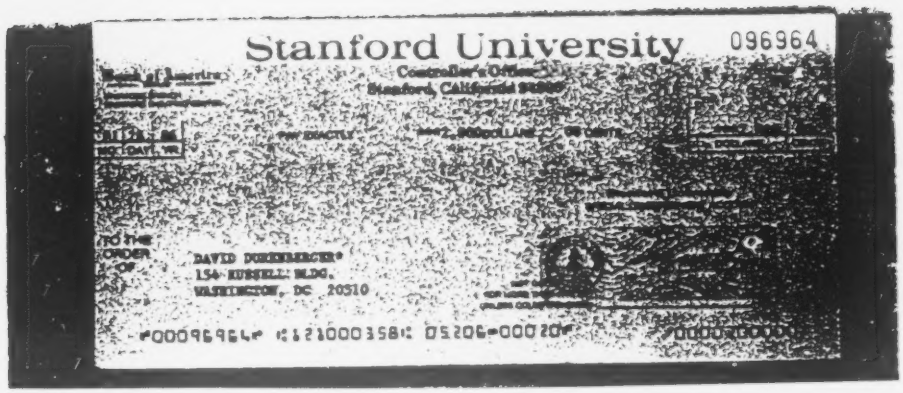
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WASHINGTON, DC 20510
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ACCOUNT NAME: Ctr For Economic Pol Rsch
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PAGE 3

DATE 02-25-35

10,534

EXPENDITURE STATEMENT

EXPENSE CLASS	ENTRY CODE	REFERENCE NO.		CURRENT MONTH EXPENSE	DESCRIPTION	TO DATE	OUTSTANDING COMMITMENTS
					EXPENDABLE MAT. & SERV.	1,537.25	
631					Subsistence	83.76	
631	21	E7613	192353	83.76 ✓	THE NEW LEAF CATERIN. BC	251.54	
631	21	E7681	192357	251.54 ✓	STANFORD FACULTY CLUB Advisory	92.02	
631	21	E7861	192362	92.02 ✓	SAGA ADVIS	78.21	
631	27	00278	192364	78.21 ✓	DOSCIN M Research	421.45	
631	21	E7440	192373	421.45 ✓	STANFORD PARK HOTEL ADVIS	2,124.30	
631	27	00279	226261	2,124.30 ✓	CATERING BY THE CONRAD ADVIS	83.75	
631	21	R1908	780620	83.75 ✓	PORTER RENTS Assoc	4,577.59 ○	○
631				3,140.03 ○	Subsistence TOTAL	33.50	
632					Designated Services	7.50	
632	27	96633	192355	7.50 ✓	MOFFETT K FUND	7.50	
632	27	03253	192400	7.50 ✓	SAINT BRIDES M Assoc	48.50 ○	○
632				15.00 ○	Designated Services TOTAL	9,000.00	
640					Professional Services	2,000.00	
640	22	02136	151387	2,000.00 ✓	DURENBERGER DAVID (SEN& Advis	11,070.00 ○	○
640				2,000.00 ○	Professional Services TOTAL	430.00	
643					Negotiated Agreements		13,000
643	32	02134	P84733			430.00 ○	13,000 ○
643				○	Negotiated Agreements TOTAL	3,115.13	
644					Technical Services	45.00	
644	27	97925	151391	45.00 ✓	MITCHELL SUSAN LEE ADVIS	232.33	
644	21	F0065	808630	232.03	OLSTEN OF PALO ALTO	3.70	
644	21	F0067	808630	63.70	OLSTEN OF PALO ALTO	3,455.88 ○	○
644				340.73 ○	Technical Services TOTAL	1,273.67	
644					Printing Services	37.45	
646	21	C2450	2G3280	37.45 ✓	REPROGRAPHEX Advisory	93.03	
646	21	E7851	192369	93.03 ✓	DOUGLAS PRINTERS ADVIS	521.34	
646	21	E7427	780604	521.34 ✓	COMMUNITY GRAPHICS } Brochure	116.56	
646	21	E7428	780604	116.56 ✓	COMMUNITY GRAPHICS }	94.00	
646	21	E7429	780604	94.00 ✓	COMMUNITY GRAPHICS	3,063.41	
646	21	F4995	780605	3,063.41 ✓	D-D ASSOCIATES INC Brochure	5,295.46 ○	○
646				4,020.73 ○	Printing Services TOTAL	4,959.90	
650					Tel & Tel Serv	838.10	
650	28	02006		838.10	ITS-COMMUNICATIONS SCV	5,797.00 ○	○
650				838.10 ○	Tel & Tel Serv TOTAL	41.70	
660					ITS-Computing Services	1.46	
660	21	02002	L80L0	1.46 ✓	ITS COMPUTING CHARGES	5.33	1,
660	28	02002	L90J5	5.33 ✓	ITS COMPUTING CHARGES JE	130.43 ○	
660				6.79 ○	ITS-Computing Services TOTAL		

[redacted]

INVOICE

TO: Gordon MacKay, New England Life

FOR: SPONSORSHIP, 1985 BUSINESS ISSUES SEMINAR
NOVEMBER 23-26, 1985
INNISBROOK
TARPON SPRINGS, FLORIDA

AMOUNT DUE: $ 1,000.00

Please make your check payable to:

STATE GOVERNMENT EDUCATION AND RESEARCH FOUNDATION (SGERF)
1001 Connecticut Avenue, N.W.
Suite 800
Washington, D.C. 20036

Please forward check by September 14, 1985 with a copy of this invoice.

Thank you!

Note: SGERF is a tax exempt charitable organization under section 501 (c) (3) of the Internal Revenue Code (see attached letter).

COMP	ACCOUNT	TYPE	SUB ACCOUNT
0 1 0 3 5	0 4 1 0		

DIV.	DEPT.	PROJECT NUMBER	TYPE
1	4 1 0 3		

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A

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State Governmental Affairs Council

1001 Connecticut Ave., N.W., Suite 800, Washington, D.C. 20036 (202) 659-7605

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October 22, 1985

Dear Business Issues Seminar Speaker:

Enclosed please find information on the upcoming Business Issues Seminar (BIS) where you will be a program participant. Please take a moment to review the agenda and background information. You will find a seminar registration form which should be completed and returned to the State Governmental Affairs Council (SGAC) at 1001 Connecticut Avenue, N.W., Suite 800, Washington, D.C. 20036. While we are fully aware that your appearance on the program is confirmed, this form will provide additional details we need to assure proper processing of on site materials for you.

Please also complete your hotel reservation form, your ground transportation form, and a special speakers' logistical needs form, returning all of these to me at SGAC headquarters as well. If you have any special requirements for your address or otherwise, be sure to note them on the speakers' logistical needs form.

If you have not already sent your curriculum vitae and a glossy headshot/portrait to your initial SGAC member contact, please send it to my office immediately. These need to be included in the printed program. We are working under a November 1 deadline for all copy and photos. We would also be happy to include background papers (up to 10 pages per speaker) in the registrants' notebooks. Please forward these as well.

Finally, please bring with you to the meeting a copy of the prepared text of your speech.

Should you have any questions, contact SGAC headquarters at (202) 659-7605, and ask for Mary Hugh Anderson or Valerie Smith. We look forward to seeing you at Innisbrook next month.

Enclosures
cc: Freeman Smith, Parker Sherrill, Warren Tardy, William Mullen, Ted Allison, Michael Lunceford

B

SENATOR DAVE DURENBERGER

Senator Durenberger has served in the United States Senate since 1978. He serves on three Finance subcommittees, and in his fifth year as chair of the Health Subcommittee, has become the acknowledged Congressional leader in health care financing reforms. The Health Subcommittee includes in its jurisdiction the $80 billion Medicare and Medicaid programs. Senator Durenberger also chairs the Subcommittee on Intergovernmental Relations which is the key federalism panel in the Senate, covering federal/state/local government issues from natural resources to tax policy.

Durenberger earned his bachelor's degree from St. John's University and received his law degree from the University of Minnesota Law School. He has devoted considerable time to health issues and has taken the lead on a wide range of legislative initiatives. He has earned a reputation as an innovator in redefining the role of government and as a leader in the effort to make public services more efficient and responsive to people's needs. Durenberger has been singled out for awards by dozens of health care organizations such as the American Public Welfare Association, the American Hospital Association, the Minnesota Hospital Association, and the National Association of Children's Hospitals.

WILLIAM B. SCHWARTZ

Dr. William B. Schwartz is a Professor of Medicine and Vannevar Bush University Professor at Tufts University. In his early career he was head of the Nephrology Division at the Tufts-New England Medical Center.

Dr. Schwartz is a past president of the American Society of Nephrology (medical kidney specialists) and a former chairman of the Scientific Advisory Board of the National Kidney Foundation. He was also chairman of the General Medicine Study Section of the National Institutes of Health. From 1971 to 1976, Dr. Schwartz was Chairman of the Department of Medicine at Tufts University School of Medicine and Physician-in-Cheif at the New England Medical Center.

In recent years, Dr. Schwartz has worked mainly in the area of health policy, concentrating primarily on the application of economics to problems of health care delivery. During this time he has published extensively on issues such as physician distribution, medical malpractice, potential cost savings in the hospital sector, and the implications of cost containment on quality of care. His most recent work consists of a prize-winning book, published jointly with Henry J. Aaron of the Brookings Institution, entitled The Painful Prescription: Rationing Hospital Care. Dr. Schwartz is a member of the Institute of Medicine, National Academy of Sciences and the American Academy of Arts and Sciences, and is also principal advisor to the Health Sciences Program of the Rand Corporation.

C

Jack A. Meyer is resident fellow in economics and Director of the American Enterprise Institute Center for Health Policy and Research. He also served as the assistant director of the U.S. Council on Wage and Price Stability.

Mr. Meyer will address the public and private sector responsibilities for financing the health care system. Meyer will discuss cost shifting, alternative financing methods such as taxes and the dangers of not recognizing the necessity of public/private contributions to stabilize our health care economy.

7. "All changes to Medicare should be considered not as methods to preserve what was, or systems for producing short term savings, but rather as efforts to make Medicare fit the real needs of our aging population for the years to come." -- Willis B. Goldbeck

Willis B. Goldbeck is President of the Washington Businesss Group on Health and Publisher of the monthly magazine "Business and Health".

Mr. Goldbeck will address the implications of the federal deficit reduction process on the Medicare program and how the various proposals may impact the business community. He will also discuss the responsibilities of business and Congress to maximize the allocation of our health care resources.

8. James R. Tallon is a New York State Assemblyman and chairman of the Assembly Health Committee. Assemblyman Tallon has also served in the New York State Council on Health Care Financing and is a member of the National Conference of State Legislatures Health and Human Resources Committee.

Assemblyman Tallon will discuss the current and future role of the public sector in managing and financing the health care system. He will also address the difficult task facing state government to balance scarce health resources against increasing public demand for these services.

9. "We are talking about putting money up front in order to save in the future." -- David Durenberger

David Durenberger is a United States Senator from Minnesota.

Senator Durenberger will address the Federal perspective to resolving health care issues. Senator Durenberger will discuss the responsibility of the federal government to examine the delayed benefits as well as short range benefits we may expect from health care investments. As a Republican Senator cosponsoring legislation with a Democratic Senator, Durenberger may also relate the importance of a unified non-partisan approach to resolving health care problems for society in general.

October 22, 1985

Jodi Mathison
Senator David Durenberger's Office
Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Mathison:

Please find enclosed an additional registration packet for the SGAC Business Issues Seminar.

I understand that Gordon Mackay of New England Life has already personally delivered these materials to the Senator for his information and that Lisa of Gordon's office, has been handling the Senator's travel and lodging arrangements.

The following memorandum explains what materials and details should be submitted directly to SGAC Headquarters by the Senator

Thank you for your attention to this request. Please feel free to contact me at SGAC Headquarters should you have any questions.

Sincerely,

Valerie Gene Smith
Director of Administration

E

To Lisa (w/ Gordon MAKAY)

SGAC NCSL

Business Issues Seminar Preliminary Program

"The States and Business: Planning for America's Health Care in the 1990's"

November 23-26, 1985
Innisbrook Resort
Tarpon Springs, Florida

Saturday, November 23, 1985

3:30-5:30PM	Business Issues Seminar Registration — Reception Center
6:30-7:30PM	Welcoming Reception — Sandpiper Pool (Rain: Tamarron A & B)
Dinner	Open

Sunday, November 24, 1985

AM	Open Time — Golf & Tennis (Optional)
1:00-2:00PM	Business Issues Seminar Registration — Tamarron Foyer
2:00-5:45PM	**Opening Plenary Session and Breakout Sessions — Tamarron West**
2:00-2:15PM	Welcoming Remarks and Overview: John R. Whipple (McDonald's Corporation), SGAC President Representative John T. Bragg (TN), NCSL President
2:15-3:00PM	Opening Address, Dr. Thomas F. Frist Thomas F. Frist is Chairman of the Board and Chief Executive Officer of Hospital Corporation of America, the world's leading health care company. Dr. Frist will address the future of the health care system and the transition to a more competitive market. Frist will share his insight in the changing economic/reimbursement environment and its impact upon health care delivery.
3:00-4:00PM	**I. The Changing Environment** A. "Health Care in the Future," Gerald L. McManis Gerald L. McManis is President of McManis Associates, Inc., an international management and research consulting firm which offers a wide range of services including strategic and operational planning, management and organizational analysis, financial feasibility studies and market assessments. Mr. McManis will address society's industrial trends and changes and how these trends have impacted upon the health care system. McManis will discuss the transition from a capital intensive to labor intensive industry and how this transition, with others, has impacted the cost of health care.
4:15-5:45PM	B. Breakout Sessions on Topic (See room assignments listed at the end of agenda)
6:15-7:30PM	Reception — Tamarron Foyer

SGVC NCSL Business Issues Seminar

Sunday, November 24, 1985 (Continued)

7:30PM Dinner — Tamarron East

Dinner Address, U.S. Senator David Durenberger (MN)

David Durenberger is a United States Senator from Minnesota. He chairs the Health Subcommittee of the Senate Finance Committee.

Senator Durenberger will address the Federal perspective for resolving health care issues. He will discuss the responsibility of the federal government to examine the delayed benefits as well as short-range benefits we may expect from health care investments. As a Republican Senator co-sponsoring legislation with a Democratic Senator, Durenberger may also relate the importance of a unified non-partisan approach to resolving health care problems for society in general.

Innisbrook
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IN FLORIDA (800) 282-6813

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WASHINGTON DC

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Your visit to Innisbrook is very much appreciated, and our staff strives to provide the utmost in personal attention and service. A candid opinion of your Innisbrook experience would be most welcome. Of interest to you, family and friends might be one of several attractive package plans offered throughout the year. We look forward to your next visit to a Golf Hosts Resort.

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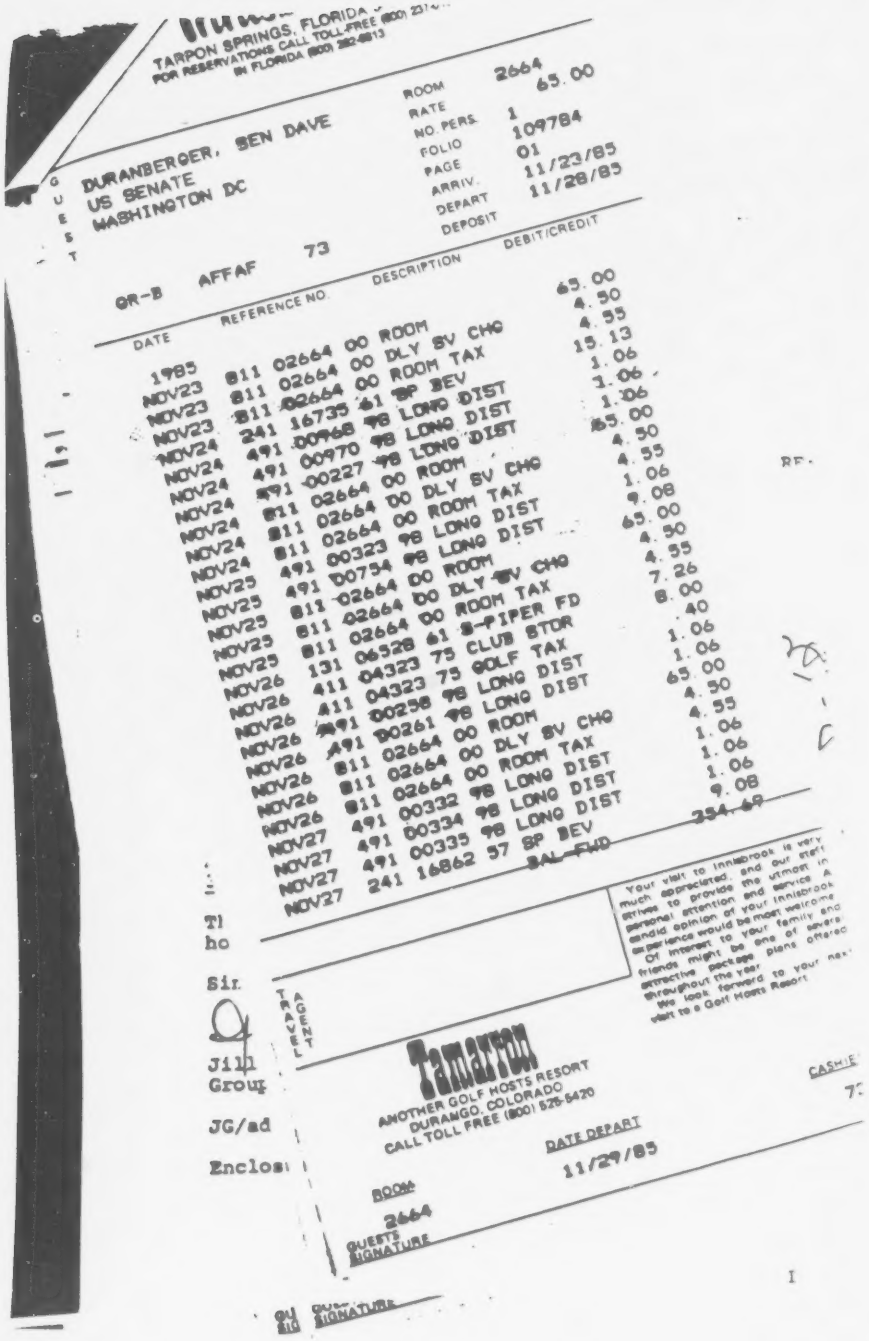

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		BAL FWD	254.69

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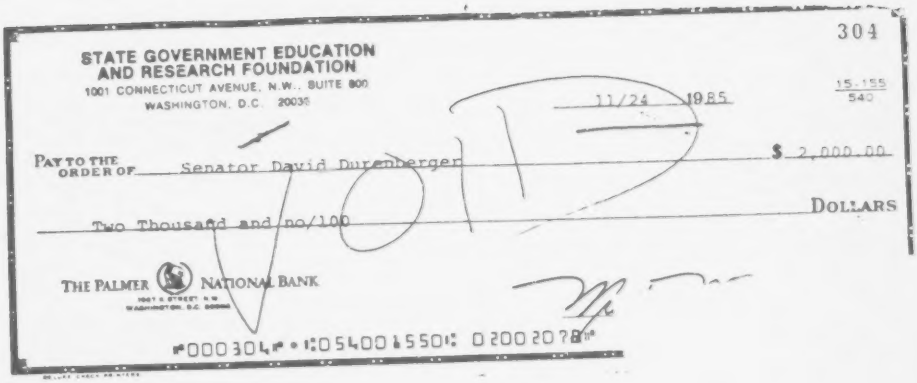

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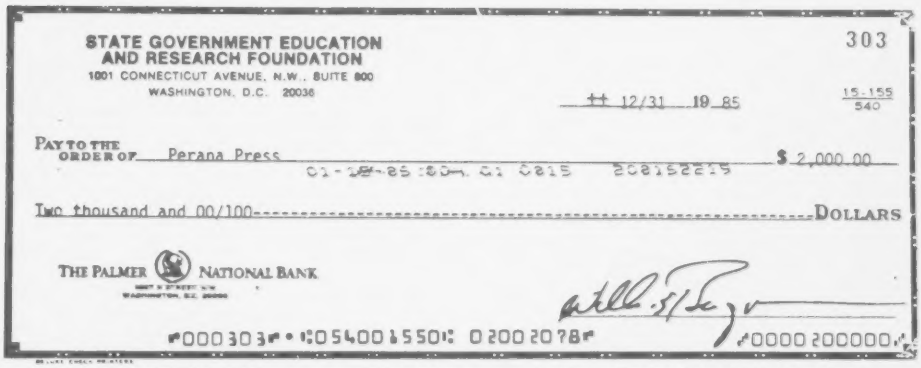

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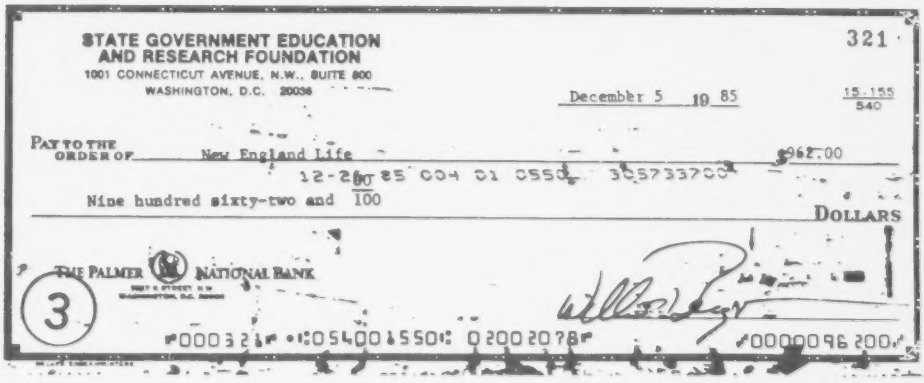

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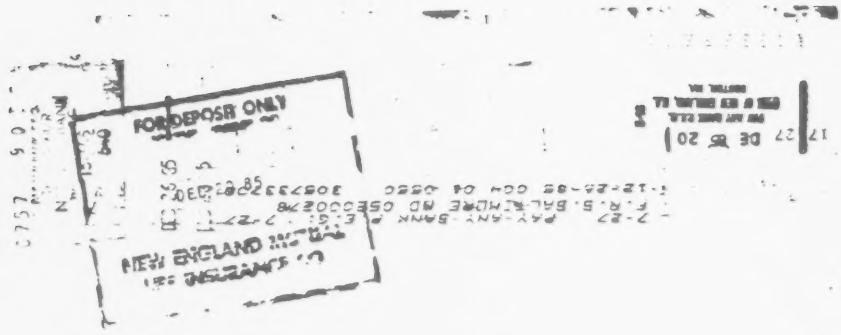

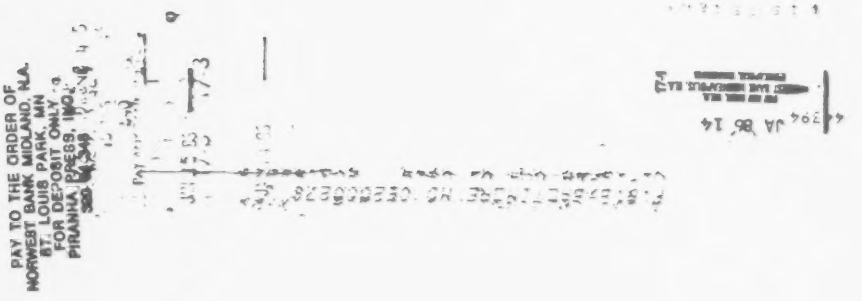

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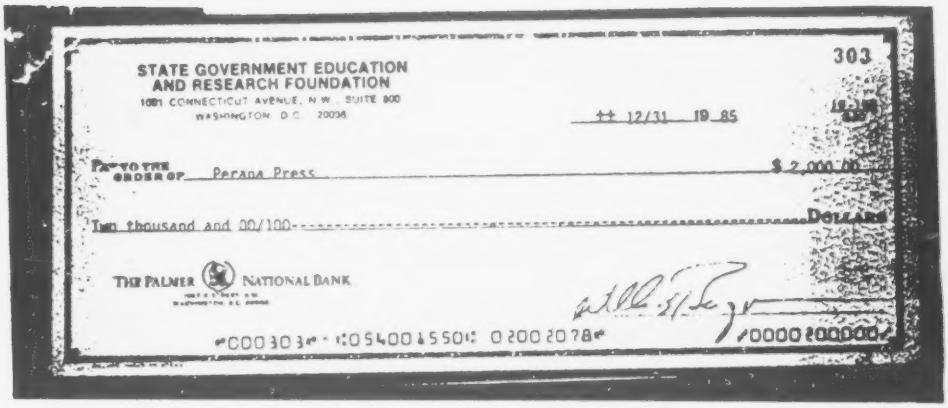

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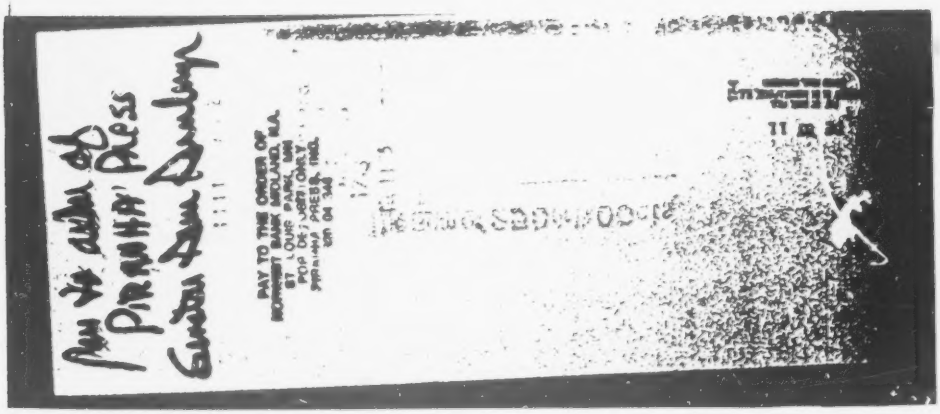
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January 2, 1986

Senator David Durenberger
United States Senate
375 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

Our thanks again, on behalf of the State Governmental Affairs Council and the National Conference of State Legislatures, for taking the time to address the business and legislative leaders at our fifth annual Business Issues Seminar on November 24, 1985. Your insights, both on the tax bill and federal budget, and on health care matters for the future, were fascinating.

Enclosed is a check payable to your publisher in the amount of $ 2,000.00, for copies of your book which we would like to make available to all participants in the seminar. Unfortunately, Gordon MacKay's office was not able to get through to your publisher before the conference so that we could hand out the books on site. Thus, we will be mailing them out from my office. Please instruct your publisher to send them to my attention at:

Ms. Marcie M. McNelis, CAE
Executive Director
State Governmental Affairs Council
1001 Connecticut Ave., N.W.
Suite 800
Washington, D.C. 20036

If there are any questions, please direct your publisher to contact either Valerie Smith or Mary Hugh Anderson in my office.

Thank you again for your time and input. We are all looking forward to having the opportunity to read your book.

Sincerely,

Marcie M. McNelis

Marcie M. McNelis, CAE
Executive Director

Enclosure: check
cc: Gordon MacKay
Jack Whipple
Freeman Smith

1985 Business Issues Seminar
Speaker Logistics

Speaker Name & Address	Photo/Bio Acquisition	Honorarium	Travel, Lodging, etc.
1. Thomas F. Frist CEO Hospital Corp. of America One Park Plaza, Box 550 Nashville, TN 37202-0550	Parker Sherrill	none	HCA
2. Gerald McManis McManis Associates, Inc. 1201 Conn., Ave., NW Washington, D.C. 20036	Parker Sherrill	$ 2,000 in-kind HCA	covered by HCA ?
3. Dr. William B. Schwartz Tuft University School of Medicine 136 Harrison Avenue Boston, MA 02111	Bill Mullin	none	SGERF will pay travel meals, lodging 11/22-11/25
4. Representative Paul Starnes 201 Broad Street Chattanooga, TN 37412	Parker Sherrill	none	SGERF will pay for travel, Comp. registration
5. Willis B. Goldbeck Director Washington Business Group 229 1/2 PA Ave, SE Washington, D.C. 20003	Bill Mullin	$ 500	SGERF will pay travel, meals, lodging
6. Marc Jeffrey Roberts Harvard School of Public Health Dept. of Health Policy & Mngmt. 677 Huntington Avenue Boston, MA 02115	Bill Mullin	$ 750	SGERF will pay travel, meals, lodging
7. Jack A. Meyer American Enterprise Institute 1150 17th Street, NW Washington, D.C. 20036	Mike Lunceford	$ 2,000	SGERF will pay travel, meals, lodging
8. James R. Tallon Legislative Office Building Room 822 Albany, NY 12248	Mike Lunceford	none	SGERF will pay travel, comp registration

Page Two
Speaker Logistics (BIS 1985)

9.	Senator David Durenburger United States Senate Russell Senate Office Bldg. Washington, D.C. 20510	Mike Lunceford	$ 2,000	SGERF will pay travel, meals, lodging
10.	Gary Janko 29 Randoll Street Canton, MA 02021	Mike Lunceford	none	not paid by SGERF
11.	Robert Helms Asst Secretary of planning and evaluation Health + Human Services 415 F ~~Hubert~~ (Hubert Humphrey Bldg) 200 Independence Ave. WDC 20 201 245-1650	Mike Lunceford	none	not paid by SGERF

New England Life

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BU-114-83

VENDOR #

VENDOR NAME (PAYEE) Senator David Durenberger

ADDRESS United States Senate

Washington, DC 20510

INVOICE DATA

VENDOR #

INVOICE #

REQUEST DATE March 17, 1986

AMOUNT OF CHECK 195.03

PAYMENT DUE DATE March 21, 1986

REASON FOR PAYMENT Reimbursement for car expenses during Business Issues Seminar in Florida, Nov. 198

| ACCOUNT | | | | | | | | | | | CENTER | | | | | | | | | | |

MEMO

MARCH 10, 1985

TO : SENATOR DURENBERGER
THROUGH: JIMMIE POWELL
FROM : BOB EBEL
RE : TOBACCO INSTITUTE SPEECH

Audience and Format (very informal)

Time : 8:00 a.m.
Place : Tobacco Institute
1875 I Street, NW
Suite 800
Contact: Ralph Venivich
457-4800
Audience: 25 people
- Executives of member companies
- D.C. staff and lobbyist
Format : Informal. Speak 15-20 minutes sitting at a conference room table.

Outline of Remarks

Message: 16 cents cigarette excise tax likely to be maintained by Congress

I. Introduction

A. Recongnize health concern
B. Tax--price relationship relevant to discouraging teenage smoking (MN study)

II. Reasons Congress is unlikely to permit October 1985 reduction of excise tax from 16 cents to 8 cents per pack

A. Federal Deficit

1. A serious concern

a. Interest cost and effect on farm economy and economy in general

b. Also, there is more to deficit control than cutting existing programs. Some new spending also necessary (es., underground water issue); so added sacrifices needed.

SPECIAL
COUNSEL
HEARING
EX. 194

A

2. Cuts of $50--55 billion needed this year

3. Society must broadly share the deficit reduction burden--tobacco institute, doctors, state/local governments, and general beneficiaries of tax expenditures.

B. Tax Reform and the Cigarette Tax

1. Awaiting the President's bill. Late April or May; we are willing to look at all of it.

2. Cigarette Tax Issue

a. Generally: the cigarette excise tax should be part of the state's revenue arsenal; however, the result is part of a larger "turnback" strategy of revenues traded for reduced categorial aid.

b. However, reserving excises for the states won't solve today's short run problems.

1. Need for federal revenue

($1.7 billion in 1985--about 3 1/2% of the $55 million deficit reduction goal.)

2. Need to avoid providing incentives for cigarette bootlegging due to interstate tax differentials.

B

MEMORANDUM

To: Bill Adams
Lonnie Buran
Donna Hilderley
Sarah Smith

cc: Phyllis McGovern
Jack Mills
Bill Prendergast
Ralph Vinovich
George Yenowine

From: Susan Ruyle

Please note the following information regarding an honorarium:

Guest: Sen. David Durenberger R MN

Member's contact:

TI's contact: MWC

Date: March 21, 1985

Time: 8:00 a.m.

Place: TI Boardroom

Amount: $2,000.

Other requirements: None

C

006012

file WWG

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006
202 457-4800 • 800 424-9876

March 12, 1985

MEMORANDUM

TO: The Washington Working Group

Steve Bull X	Burleigh Leonard ✓ + Ellis
Sam Chilcote X	Howard Liebengood X
Marlow Cook ✓	Phyllis McGovern ✓
Bob Diamond ✓	Jack Mills X
Jim Healey X	Fred Panzer ✓
Bill Hecht X	Bill Prendergast ✓
Dave Henderson ✓	Dave Satterfield ✓
Dee Huddleston ✓	Ralph Vinovich ✓
Gene Knorr ✓	Wilson Wyatt X
Horace Kornegay X	George Yenowine ✓

FROM: Bob Lewis

RE: Honorariums and Business Session

---

1. Tuesday, March 19, Representative Joseph M. Gaydos, D PA-20, will be our guest at 8:30 a.m. in the Institute's Boardroom. The Congressman's committee assignments include Education and Labor.

Following the Congressman's appearance the Washington Working Group will remain in session for a review meeting on our excise project and other legislative developments.

2. Thursday, March 21, Senator David Durenburger, R MN, will be our guest at 8:00 a.m. in the Boardroom. The Senator's committee assignments included Finance.

Please notify Susan Ruyle, 457-4846, as to whether you will, or will not, be in attendance for each of these events.

cc: ~~Paul Bergson~~
~~Ernest Pepples~~
~~Stanley Scott~~
Roger Mozingo + Bill Bunkley
Kerrigan

FEDERAL MAR 13 1985

D

THE TOBACCO INSTITUTE

CHECK REQUEST

Date: 4/9/80 March 13, 1985 Amount: $2,000.

Pay To: The Honorable
David Durenberger, U.S.S.

Explanation: Appearance at Institute, 8:00 a.m., March 21, 1985

DISTRIBUTION OF CHARGES

Cost Center Number	Account Number	Explanation	Amount
1201	7300 20	Speaker's Honorarium	$2,000.

RECEIVED
MAR 18 1985
ACCOUNTING

Requested by: Susan Ruyle Approved by: RJ Cavi

Put check in mail ☐ Return check to me for transmittal ☑

Need by: Wed., March 20, 1985

000001

THE RIGGS NATIONAL BANK
LINCOLN OFFICE
WASHINGTON, D.C.

DM

55-3
540

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006

CHECK NO.	CHECK DATE	AMOUNT
19594	Mar. 18, 1985	****2,000.00

PAY *TWO THOUSAND AND 00/100 DOLLARS*

TO THE ORDER OF

DAVID DURENBERGER

IN SYSTEM ✓
IN BOOK ✓

VOID
3.26.85
pay to diff vendor

⑈019594⑈ ⑆054000030⑆ 12=08219752⑈

000002

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006
202 457-4800 • 800 424-9876

ROBERT J. LEWIS
Senior Vice President for
Federal Relations

March 21, 1985

The Honorable
David Durenberger
375 Senate Russell Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Tobacco Institute, I would like to thank you for your appearance at today's breakfast meeting and for your address to our staff, member-company representatives and counsel regarding issues of mutual concern.

As an additional gesture of the Institute's appreciation, I have enclosed an honorarium of $2,000. Shortly after the end of the calendar year we will mail you your Form 1099 which reports this payment to the Internal Revenue Service.

Again, thank you for accepting our invitation and for sharing your candid views. It was a distinct privilege to have you add us to your busy schedule.

Best personal regards,

Sincerely,

Robert J. Lewis

Enclosure

RJL/sr

G

000004

THE TOBACCO INSTITUTE

1875 I STREET, NORTHWEST
WASHINGTON, DC 20006
202 457-4800 • 800 424-9876

ROBERT J. LEWIS
Senior Vice President for
Federal Relations

March 22, 1985

The Honorable
David Durenberger
375 Senate Russell Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Tobacco Institute, I would like to thank you for your appearance at our breakfast meeting and for your remarks to our staff, member-company representatives and counsel regarding issues of mutual concern.

A donation of $2,000 has been made in your name to Piranha Press.

Again, thank you for accepting our invitation and for sharing your candid views. It was a distinct privilege to have you add us to your busy schedule.

Best personal regards,

Sincerely,

Robert J. Lewis

RJL/sr

H

000008

THE TOBACCO INSTITUTE

CHECK REQUEST

095220

Date: March 25, 1985 Amount: $2,000.

Pay To: Piranha Press
4504 Excelsior
Minneapolis, MN 55416

Explanation: Sen. David Durenberger honorarium for appearance at Institute.
March 21, 1985 designated for payment to Piranha Press

DISTRIBUTION OF CHARGES

Cost Center Number	Account Number	Explanation	Amount
1201	1330 ~~7300~~	Piranha Press	$2,000

3/25/

MARY,
SEN. DURENBERGER
HAS REQUESTED
HIS HONORARIUM
BE DONATED
TO PIRANHA PRESS
THANKS
SR.

RECEIVED
MAR 26 1985
ACCOUNTING

Requested by: Susan Ruyle Approved by: RJ Lewis

Put check in mail ☐ Return check to me for transmittal ☑

Need by: ASAP

000005

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006

THE RIGGS NATIONAL BANK
LINCOLN OFFICE
WASHINGTON, D.C.

CHECK NO.	CHECK DATE	AMOUNT
19853	Mar. 27, 1985	****2,000.00

PAY *TWO THOUSAND AND 00/100 DOLLARS*

04-03-85 004 03 0800 508037727

TO THE ORDER OF

PIRANHA PRESS
4504 EXCELSIOR
MINNEAPOLIS, MN 55416

W. A. Adams

⑈019853⑈ ⑆054000030⑆ 12-08219752⑈ ⑈0000200000⑈

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
320 04 348

PAY ANY BANK, BFG
NEW YORK, NY
17-3

000006

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006

THE RIGGS NATIONAL BANK
N OFFICE
WASHINGTON, D.C.

CHECK NO.	CHECK DATE	AMOUNT
19853	MAR. 27, 1985	[illegible]

PAY *TWO THOUSAND AND 00/100 DOLLARS*

TO THE ORDER OF

PIRANHA PRESS
4504 EXCELSIOR
MINNEAPOLIS, MN 55416

NON-NEGOTIABLE

⑈019853⑈ ⑆054000030⑆ 12-08219752⑈

DETACH BEFORE DEPOSITING. NO OTHER RECEIPT REQUIRED

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006

VENDOR NUMBER	CHECK DATE	CHECK NUMBER
[illegible]	3-27-85	19853

INVOICE DATE	INVOICE NUMBER	MEMO INFORMATION		ENTRY NUMBER	AMOUNT
3-25-85	DIRECTMASTER	HONORARIUM		21071	[illegible]

[illegible]

CCDE	ACCT	JOB#	[illegible]
1201	7330		[illegible]

K

000007

THE TOBACCO INSTITUTE, INC.

Federal Relations Congressional System
Member Honoraria Memo - (MCHOM)

FID: 464 ALPHA: DURENBERGER, DAVID FERDINAND R MN

MEMO (Y/N): '85: original honorarium check cancelled and redrawn to "Piranha Press, Minneapolis" at member's request 3-22.

THE TOBACCO INSTITUTE
1875 I STREET, NORTHWEST
WASHINGTON, DC 20006
202 457-4800 • 800 424-9876

ROBERT J. LEWIS
Senior Vice President for
Federal Relations

March 28, 1985

Piranha Press
4504 Excelsior
Minneapolis, MN 55416

Dear Sir:

The Tobacco Institute is making the enclosed payment to Piranha Press.

U.S. Senator David Durenberger, a participant in a March 21, 1985 Institute-sponsored seminar advised us to disburse the funds in this manner.

Please feel free to contact me if you require additional information.

Sincerely,

Robert J. Lewis

Enclosure

cc: The Honorable
David Durenberger

RJL/sr

M

000009

CUMULATIVE GENERAL LEDGER, PERIOD ENDING 12-31-85

	MO	JL	ENT. NO.	CHECK DATE	CHECK NUMBER	VENDOR OR DESCRIPTION	AMOUNT
CLOSING BALANCE							258,538.58
1201 7330 HONORARIA PAYMENTS							
OPENING BALANCE							0.00
	1	AP	45	01-04-85			1,000.00
	1	AP	47	01-04-85			1,000.00
	1	AP	49	01-04-85			2,000.00
	1	AP	51	01-04-85			1,000.00
	1	AP	53	01-04-85			1,000.00
	1	AP	55	01-04-85			2,000.00
	1	AP	57	01-04-85			1,000.00
	1	AP	59	01-04-85			2,000.00
	1	AP	61	01-04-85			2,000.00
	1	AP	63	01-04-85			1,000.00
	1	AP	65	01-04-85			2,000.00
	1	AP	67	01-04-85			1,000.00
	1	AP	69	01-04-85			1,000.00
	1	AP	71	01-04-85			1,000.00
	1	AP	72	01-04-85			1,000.00
	1	AP	73	01-04-85			2,000.00
	1	AP	77	01-04-85			1,000.00
	1	AP	1473	01-24-85			2,000.00
	1	AP	1907	01-31-85			1,000.00
CLOSING BALANCE							28,000.00
	2	GJ	13	01-24-85			2,000.00
	2	GJ	14	01-24-85			(2,000.00)
	2	GJ	23	01-30-85			1,000.00
	2	GJ	15	01-31-85			1,000.00
	2	GJ	16	01-31-85			(1,000.00)
	2	AP	99	02-04-85			2,000.00
	2	AP	481	02-12-85			2,000.00
CLOSING BALANCE							31,000.00
	3	AP	259	03-08-85			2,000.00
	3	AP	289	03-08-85			1,000.00
	3	AP	823	03-11-85			2,000.00
	3	AP	1299	03-18-85			1,000.00
	3	AP	1683	03-21-85			1,000.00
	3	AP	1998	03-28-85	19853	PIRANHA PRESS	2,000.00
CLOSING BALANCE							40,000.00
	4	AP	141	04-01-85			1,000.00
	4	AP	1119	04-11-85			1,000.00
	4	AP	1121	04-11-85			1,000.00
	4	AP	2303	04-26-85			2,000.00
	4	AP	2407	04-30-85			1,000.00
CLOSING BALANCE							46,000.00
	5	AP	599	05-08-85			1,000.00
	5	AP	1023	05-14-85			1,000.00
	5	AP	1803	05-24-85			1,000.00
CLOSING BALANCE							49,000.00
	6	AP	1017	06-14-85			1,000.00
	6	AP	1287	06-18-85			2,000.00

1985 GL

1201 7330

000010

561

PRODUCED ON 01- 1-86

Z

PR

TRAVENOL LABORATORIES, INC.

Washington Office

1667 K Street, N.W.
Suite 710
Washington, D.C. 20006
(202) 223-4014

W. BRADFORD GARY
Director
Government Affairs

DEERFIELD, ILLINOIS 60015
CABLE TRAVENOL DEERFIELD
TELEX 72-0497

December 18, 1985

173 1452

Mr. Doug Kelly
Administrative Assistant
Office of the Honorable
David Durenberger
United States Senate
SR-154 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Doug:

Thank you for your interest in having the Senator visit the Baxter Travenol plant on the Island of Culebra, Caribbean Sea, Puerto Rico during his December 27 - January 3, 1986 visit to the Commonwealth.

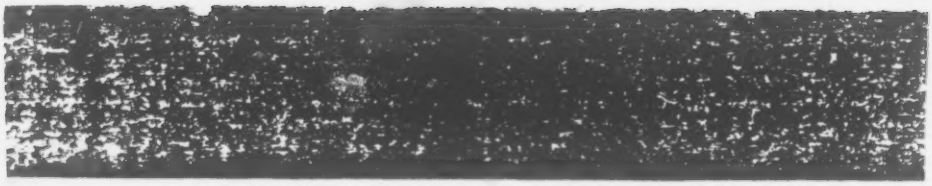
We would be delighted to host the Senator at our manufacturing facility at Culebra on Tuesday afternoon, January 2nd. We will arrange air transportation via the Travenol executive helicopter to and from Culebra from the Dorado Airport departing at 1:00 p.m. and returning from Culebra at 5:00 p.m., Atlantic time.

While on the Island of Culebra, the Senator will meet with Travenol employees and the Mayor of Culebra, Anastasio Soto Ayala. A description of Travenol/Culebra is found on the last page of the enclosed brochure.

In connection with this event, we are pleased to offer an honorarium of $2,000 to the Senator or an organization of his choice.

SPECIAL
COUNSEL
HEARING
EX. 195

A



Thank you for you interest in Baxter Travenol and our Puerto Rican operations.

Regards,

W. Bradford Gary

WBG:cmh
enclosures: 3

1 / 3 1 4 5 2

B

Claire -
Can you do check request for:

Check this wording w/ Mike →

U.S. Senator David F. Durenberger
Honorarium - Congressional Visit
to Traverse / Culebra

1 / 3 1 4 5 2

make check to:
Piranha Press
4504 Excelsior Blvd.
Minneapolis, Minn. 55416

* Durenberger's Social Security #:
471-36-4210

* I checked w/ Ryan DeBee - this is sufficient.

Put a "PLEASE RUSH" on it, too!

Thanks!

A

c

THE WASHINGTON OFFICE December 18, 1985

Dear Lynn,

This is a check request for an honorarium for Senator David Durenberger.

He will be speaking at the Culebra facility in Puerto Rico on January 2nd.

Enclosed is the letter from Brad to the Senator's Administrative Assistant, Doug Kelly inviting the Senator to speak and offering an honorarium of $2,000.00.

I hope that this will suffice as an invoice of sorts. However if there are any problems, please do not hesitate to contact Julie Arnold or me.

Also, could you please put a RUSH on this? Thanks so much for your help, and I hope that you and your family have a wonderful holiday season.

Claire

1452

Julie, will Mr fly in w.w.?

- CMH

D

TRAVENOL

CHECK REQUEST

PROTECT ABOVE MICROFILM BARCODE AND TOP EDGE FROM DAMAGE
INSTRUCTIONS ON BACK – TYPE OR PRINT LEGIBLY
SHADED NUMBERS ARE REQUIRED INFORMATION

CHECK REQUEST NO 139,95

1 DATE: MO 12 DAY 11 YR 85

2 DESCRIPTION AND REASON FOR DISBURSEMENT:
(Attach Supporting Documentation. Number of Pages ____)

U. S. Senator David F. Durenberger / 3 PLEASE RUSH ; 2
Honararium - Congressional Visit to
Travenol-Culebra

Travenol/Washington

3 INVOICE INFORMATION
☐ CHECK IF NOT APPLICABLE
A NUMBER
B DATE
C PAYMENT TERMS ☐ NONE

4 DATE CHECK REQUIRED: MO 12 DAY 18 YR 85 | ACCOUNTS PAYABLE USE ONLY: T16 1 092353470

11 ACCOUNT NUMBER: 71-911306-702

12 AMOUNT (U.S. DOLLARS): $ 2,000 00

5 PAYEE NAME: Piranha Press
STREET ADDRESS: 4504 Excelsior Blvd.
CITY: Minneapolis STATE: Minnesota ZIP CODE: 55416

6 PAYEE TAX IDENTIFICATION NUMBER (Check One)
☐ TRAVENOL EMPLOYEE SS No
☐ COMPANY FEIN
☒ INDIVIDUAL SS No 471-36-4210
☐ GOVERNMENT AGENCY (Tax I.D. not required)
☐ FOREIGN VENDOR I.D. No (if no I.D. see instructions)
☐ AUTHORIZED EXCEPTION
S.C. 6006

7 DISBURSEMENT CONTROL NUMBER
☐ PURCHASE ORDER # ☐ RCA #
☐ PROJECT # ☐ MEA #
☒ NOT APPLICABLE EXPLAIN IN DESCRIPTION [2]

8 CHECK DISPOSITION
A ☒ MAIL TO PAYEE B ☐ MAIL TO OTHER THAN PAYEE (An Attached Pre Addressed Envelope)
1 ☐ RETURN CONFIRMATION
2 ☐ SEND ATTACHMENT (If enclosed in Pre Addressed Envelope)

12A TAX
12B FREIGHT
TOTAL $ 2,000 00

9 ORIGINATOR'S NAME: Claire M. Halloran Gov't Affairs Travenol/WDC DEPT 8901 LOC EXT

13 REMITTANCE MESSAGE: TO BE DETACHED

10 UNDER $1,000 MANAGER'S APPROVAL
SIGNATURE | DATE | NAME & TITLE

14 DIVISION FUNCTION CONTROL NUMBER / STAMP

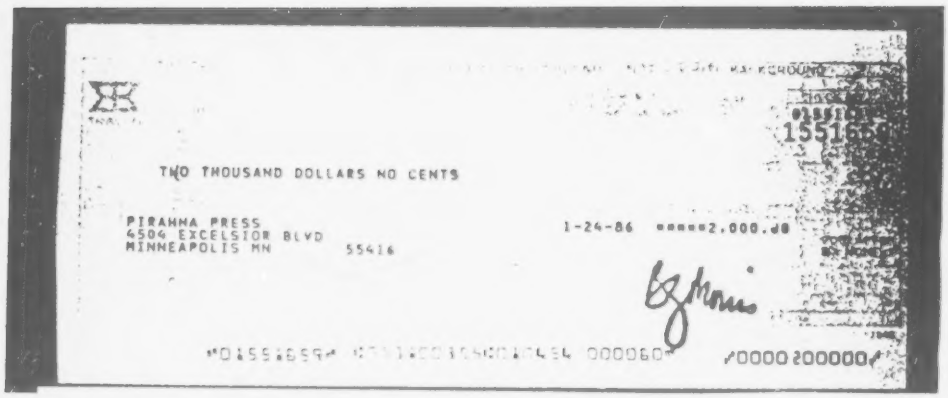
ACCOUNTS PAYABLE USE ONLY: RECEIVED

APPROVAL
$1,000 - $5,000 DIRECTOR'S APPROVAL
SIGNATURE: W Bradford Gary | DATE: 12/18/85 | NAME & TITLE: W. Bradford Gary Travenol/WDC

OVER $5,000 VICE PRESIDENT'S APPROVAL
SIGNATURE: A. Glenn

ATTACHMENTS

E

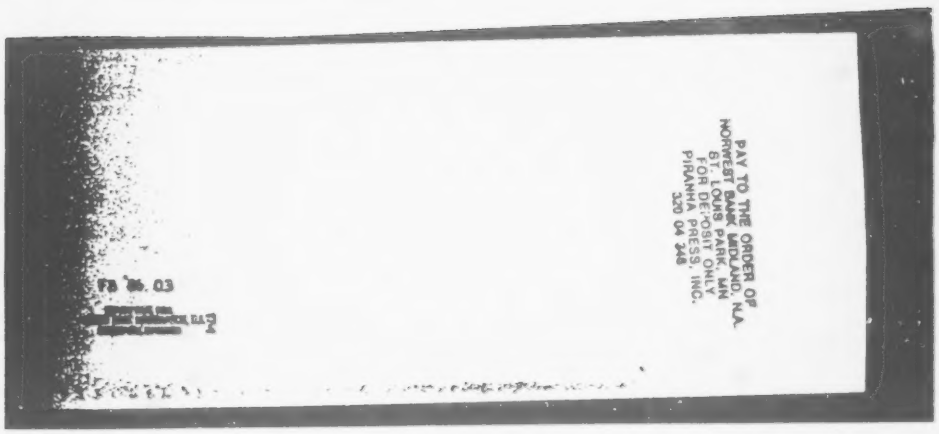


1551

TWO THOUSAND DOLLARS NO CENTS

PIRAHNA PRESS
4504 EXCELSIOR BLVD
MINNEAPOLIS MN 55416

1-24-86 *****2,000.00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NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
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PIRANHA PRESS, INC.
320 04 248

Vol. 4, No. 1 ★ Spring Edition

BAXPAC ★ Perspective

Baxter Travenol Laboratories, Inc.
Political Action Committee (BAXPAC)

Senate Health Chief Durenberger Visits Travenol/Culebra; Pledges Help on Puerto Rico Health And Tax Matters

U.S. Senator David Durenberger (center) discusses Puerto Rico health care and tax matters with Neil Romero (l), Julio Noriega and Brad Gary of Travenol during Culebra plant tour on January 2, 1986.

(Culebra, PR) – The day after New Year's on the tiny Caribbean island of Culebra was especially active with the visit of U.S. Senator David Durenberger, the Chairman of the Health Subcommittee of the U.S. Senate, the Sergeant at Arms of the U.S. Senate, Ernest Garcia, and Senator Durenberger's chief health policy advisor, Chip Kahn, and his wife Mary.

Durenberger's party was flown to Culebra from San Juan by Travenol on Puerto Rico government helicopters and visited the Travenol Culebra facility where they were hosted by Plant Manager Julio Noriega, Neil Romero of the Human Resources staff and Brad Gary of Travenol-Washington. Travenol sponsored a dinner with Culebra Mayor Anastasio Soto Ayala, at the Pescador restaurant after the plant tour.

Durenberger's visit to Puerto Rico was scheduled to familiarize the Minnesota Senator with two key problems that the island faces in 1986 – the possible repeal of Section 936 of the Internal Revenue Code which provides for tax-free manufacturing in the Commonwealth and the question of whether the Medicare Prospective Payment System for hospitals should be extended offshore to Puerto Rico. Currently the island's hospitals operate under the old cost reimbursement system that was repealed on the mainland in the early 1980s. Durenberger indicated that he was interested in seeking solutions to both issues that "did not disadvantage the people of Puerto Rico."

Veteran Carolina Congressman Seeks Open Senate Seat

U.S. Representative Jim Broyhill (R-NC) greets Travenol/North Cove employees during December 9, 1985 BAXPAC tour.

(North Cove, NC) – The senior member of the North Carolina Congressional Delegation, Congressman Jim Broyhill, spent over two hours touring the Travenol/North Cove facility and meeting with employees during a BAXPAC-sponsored tour on December 9, 1985.

Congressman Broyhill was instrumental in working for adoption of the 1982 federal regulation that encouraged the use of company home dialysis products, manufactured at the North Cove facility. Broyhill – in addition to being the leading contender for the open Senate seat in North Carolina – is the ranking Minority Member of the Committee on Interstate and Foreign Commerce which has jurisdiction over the federal Food and Drug Administration, the federal agency that supervises the nation's drug and medical device laws.

Broyhill was escorted through the North Cove facility by Plant Manager Ed Ogelsby and Brad Gary of the Travenol/Washington office. The Trustees of BAXPAC recently decided to contribute to the Broyhill for Senate Campaign Committee, based on the Congressman's active role in Washington health policy matters.

H

BAXPAC PERSPECTIVE is the newsletter of the employee-sponsored Baxter Travenol Political Action Committee. BAXPAC is on BAXPAC Drive to TRAVENOL WASHINGTON. A report on the efforts of the Federal Election Commission, 1325 K Street, N.W., Washington, D.C. BAXPAC is a registered Federal committee.

U.S. Senator Paul Simon Visits Deerfield; Promotes BAXPAC

U.S. Senator Paul Simon (D-IL) discusses company merger with Travenol executives. Pictured are: BAXPAC Chairman John Noble; Senator Simon; Tom Cody; Greg Hudson; and Tom Hudson.

(*Deerfield, IL*) – On February 14, 1986, BAXPAC had the honor of welcoming Senator Paul Simon (D-IL) to corporate headquarters in Deerfield. The Senator from Illinois has served the state for the past 30 years. He began his career in public office as a member of the Illinois House of Representatives in 1955. From there he held office in the Illinois State Senate for six years. In 1969 he was elected Lieutenant Governor, and represented the state in that capacity for four years. After serving at the state level for twenty-two years, Paul Simon moved onto the national level, and was a member of the U.S. House of Representatives from 1974 to 1984. Elected in 1984, Paul Simon now represents Illinois in the U.S. Senate.

After his many years of service to Illinois, Senator Simon is no stranger to Baxter Travenol. In a morning meeting with senior executives, Simon reviewed his relationship with the company, and discussed his knowledge of the issues of particular importance to Baxter Travenol, and his interpretation of the merger. Tom Cody, Vice President for Human Resources, and Richard Egan, head of the merger transition team, briefed him with information on the new company.

Senator Simon is greeted by Corporate Vice President Terry Mulligan as BAXPAC Trustee Fred Grossman looks on.

During the afternoon, Simon continued his visit by addressing an employee-wide gathering in the auditorium. The topic of Simon's talk was both timely and of particular interest to Baxter Travenol as a health care firm. Deliberations concerning the budget deficit have become the major priority for the nation in both Washington and the country at large, according to Simon. He expressed particular concern over proposals to make cuts in the health care budget while the defense budget remains "virtually unscathed."

First Rhode Island Congressional Visit Held

(*Warwick, RI*) – During a September 6 visit to JS Data in Warwick, Rhode Island, U.S. Representative Claudine Schneider (R-RI-2nd), Ranking Minority Member of the Science and Technology Committee of the House of Representatives, participated in a briefing on the technological innovations in the Travenol Hospital Information Systems Division.

As a member of the Science and Technology Committee, Representative Schneider holds a particular interest in the rapid rise of the health care information systems industry. That interest carries over into a strong commitment to "make sure companies existing in Rhode Island remain solid and secure." The success of JS Data has contributed to Schneider's efforts towards establishing business incentives as a priority in Rhode Island.

Representative Claudine Schneider (R-RI-2nd)

After the briefing by JS Data President Ron Young, Schneider toured the facility which was recently opened just last June. During an employee-wide reception following the tour, Schneider spoke with employees about her activities in Washington.

BAXPAC Advisory Board Encourages Participation

Integral to the effectiveness of BAXPAC is the Plant Advisory Board. Bill Fennelly, Vice President – Manufacturing, chairs the board and continues in his firm commitment to responding to the political interests of Travenol employees at all facilities. Along with Mr. Fennelly, David Rogers and Maurice Lucas of the Cleveland, Mississippi facility, Harold Hambrice and Bob White of the Mountain Home, Arkansas facility, and Jane Melton and Howard Baker of the North Cove, North Carolina facility serve on the Plant Advisory Board.

William Fennelly
Plant Advisory Board
Chairman and Project Management

Maurice Lucas, Jr., Cost Improvement Coordinator and David Rogers, Personnel Manager, Travenol Cleveland

Harold Hambrice
Personnel Manager
Travenol Mountain Home

Bob White
Scheduler
Travenol Mountain Home

Jane Melton
Programmer Analyst
Travenol North Cove

Howard Baker
Inventory Control
Systems Manager
Travenol North Cove

The consensus among the board members is a "call to action" for all Travenol employees to take advantage of the opportunity to contribute to BAXPAC. An effective and dynamic political action committee depends upon a vocal and interested membership. In their capacity as Plant Advisory Board members Bill, David, Maurice, Harold, Bob, Jane, and Howard strongly encourage all employees to keep themselves current with your concerns regarding political issues on all levels – local, state, and federal.

I

CAPITOL-IZING

Guest Editorial

Preventive Health Care: Healthy Beginnings for All American Children

by U. S. Senator Dale Bumpers

[Editor's note: Senator Dale Bumpers (D-AR) is a member of the Appropriations Committee where he has worked extensively to defend preventive health care from severe budget cuts. He also serves on the Energy and Natural Resources and Small Business Committees. Senator Bumpers visited Traveren/Mountain Home in May of 1985 to meet with plant employees to discuss health care issues – see BAXPAC Perspective, Vol. 3, No. 2. Currently, Senator Bumpers faces Republican Asa Hutchinson in his third Senate race.]

(Washington, D.C.) – Since 1981, the Reagan Administration has rather consistently submitted budget requests that would torpedo preventive health programs for children. Since the 1981 Gramm-Latta budget cuts, however, Congress has generally refused to go along. And I am pleased to report that the Administration's fiscal year 1987 budget request proposes some cuts in these programs but assumes that they will continue to be viable. In a marked departure from recent budget requests, none of these programs is slated for elimination. The proposed cuts for most are less severe than those for other domestic programs and some are earmarked for a slight increase in funding.

This is an acknowledgement of strong public and bipartisan Congressional support for preventive health programs for children, an acknowledgement that they are a humane and cost-effective public policy.

Despite support for preventive health programs, however, there are warning signs that the health of our children remains at risk. And the possibility – under the Gramm-Rudman-Hollings amendment – of across-the-board cuts in the range of 15%-25% in some of these programs raises serious questions about their ability to serve American children. The decisions on funding for preventive health programs are among the most important that Congress must make as it tries to balance the needs of our citizens with the need to reduce the budget deficit. Because they meet a most basic need – giving our children a healthy beginning – they must be given high priority in any budget debate.

The major programs providing preventive health care to children are the Maternal and Child Health Block Grant, the immunization program, the Preventive Health Block Grant, Medicaid, and the Supplemental Feeding Program for Women, Infants, and Children. Among the services provided by these programs are prenatal care for women, special services for crippled children, immunizations in public health clinics for many of the nation's children, and nutritional supplements for pregnant women, infants, and at-risk children.

The economic savings resulting from our investment in preventive health have been substantial. Studies on the cost effectiveness of preventive health are numerous, and the conclusions are clear. The American Academy of Pediatrics reported in 1984 that cost effectiveness estimates range from two to ten dollars saved for every dollar spent on prenatal care. And the benefits of the immunization program are even more stunning. The benefit-cost ratio of the rubella immunization given in combination with measles vaccine is estimated to be 23:1, and the benefit-cost ratio for polio immunization is 10.3:1. This translates to estimated savings of about $1 billion per year for polio and $500 million per year for measles.

Senator Dale Bumpers (D-AR)

The benefits of preventive health programs can also be illustrated in human terms. Since 1963, over 57 million cases of measles and 19,100 cases of mental retardation have been averted and 5,700 children's lives have been saved as a result of measles immunization. Nationwide, from 1970 to 1982, the infant mortality rate fell from 20 deaths per 1000 live births to 11.5 deaths per 1000 live births. In 1983, the national infant mortality rate was 10.9 per 1000 live births. In the state of Arkansas, the infant mortality rate has improved greatly in the last few years, reaching 10.7 per 1000 in 1984. Arkansas is proud to be the single southern state with an infant mortality rate below the national average; the improvement can be traced to improved access to prenatal care and to the outstanding neonatal care available through Arkansas Children's Hospital.

Despite all the good news, there are persistent problems facing us. Although the infant mortality rate has improved, the rate of improvement has slowed in recent years. Black infants still die at about double the rate of white infants, and there are wide variations in infant mortality rates from state to state. During the period 1980-82, the average annual infant mortality rates ranged from a low of 6.5 per 1000 live births in Wyoming to 15.4 per 1000 live births in South Carolina to 25.9 in the District of Columbia. And in 1979-1980, the U.S. infant mortality rate was higher than those of Sweden, Japan, Denmark, Norway, France, Canada, and Spain.

And the problem of teenage pregnancy is still severe. In 1980, almost 20% of new babies were born to unwed mothers. Last year, over half a million teenage girls had babies. The children of those teens face serious obstacles from birth. All indicators are that children born to teens are at greater risk than other infants. Teen mothers are less likely than other pregnant women to get adequate prenatal care, so their children are less likely to be born healthy. And that is only the beginning of the problems those children face: in 1983, the poverty rate for children under 18 in female-headed families was 55.8%, more than twice the high poverty rate among all children.

A matter that has been raised frequently in debate on the federal budget is the need to eliminate waste and abuse in federal programs. Certainly no program is without inefficiency or waste, but the record of the preventive health programs is very strong in that area. And the argument cannot be made that the programs are serving those who could take care of themselves. In fact, the WIC program is estimated to serve only about one-third of those who are eligible for its services. And the Medicaid program serves only a fraction of poor women and children. In Arkansas, for example, it is estimated that less than one third of the poverty population under the age of 65 is Medicaid-eligible. In fact, the number of Americans without private or public health insurance is growing. Some estimate that as much as 16 percent of the population under 65 was uninsured in 1982.

A freeze in funding for the preventive health programs will not allow us to meet the health care inflation rate and will mean fewer services to fewer women and children. For example, while the recommended 6% decrease in funding for the immunization program appears modest in light of cuts in other domestic programs, it will cause serious problems in the program. The immunization program has suffered in recent years from astronomical increases in the price of vaccine. For example, the DPT vaccine price has increased fivefold in the last two years, and another increase would not be surprising. This decrease in funding will mean fewer children served. And for every dollar we save this year, we'll spend ten or fifteen in later years on health care for those children who weren't immunized.

In this fiscal climate in which most programs will be frozen or cut, it is virtually impossible to advocate increased spending. But as we begin the debate on the FY '87 budget we must remember that our investment in preventive health programs saves the federal government money in the long run – often as much as $10 for every $1 invested. How can we fulfill the admonition of our great Constitution that we work to "secure the blessings of liberty for our posterity" if we fail to give our children a healthy beginning?

It may be an overstatement to say that the future of our nation depends upon the viability of preventive health programs, but it is no overstatement to say that our future depends upon the health of coming generations. We must control the deficits, and at the same time we must invest in the health of our precious children and grandchildren.

Chairman's Letter

by John Noble
BAXPAC Chairman

Dear Fellow BAXPAC Member:

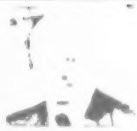
I would like to introduce myself as the new Chairman of BAXPAC. In the last few years, the health care industry has witnessed the ever-increasing impact of government decision makers. BAXPAC has the potential to become an important vehicle to articulate the concerns of Baxter Travenol to the present decision-making process of government. I welcome the opportunity to work with the BAXPAC Trustees and its members to realize this challenging goal.

On February 14, the BAXPAC Trustees gathered in Deerfield for the first meeting of 1986. With the completion of the merger, BAXPAC welcomes its newest trustees – Steve Kane, Vice President for Human Resources Administration and Fred Grossmann, Vice President – American Hospital Supply. Continuing trustees are G. Marshall Abbey, Senior Vice President and General Counsel; Bill Fenneily, Vice President – Manufacturing; Tom Hodson (BAXPAC Treasurer), Vice President – Group Operations; and Roger Lewis, Vice President.

The merger brings to BAXPAC not only the addition of two valued and talented trustees, but an exciting opportunity for increased growth in membership and participation. Essential to this growth is your continued input. The 1986 Elections promise to provide races well worth participating in. Candidates of both parties from across the country have requested contributions from BAXPAC. These same candidates need BAXPAC's contributions, but also depend upon your votes. I encourage you to let me know about the legislators whom you support, so that as your new Chairman I can then share your opinions with the BAXPAC Trustees. With your help, we can make contribution decisions which reflect your commitment to promoting the interests of Baxter Travenol, its employees, and its customers. I look forward to hearing from you.

Thank you.

BAXPAC Treasurer's Report



by Thomas Hodson
for the BAXPAC Trustees, April 1986

A meeting of the Baxter Travenol Laboratories, Inc. Political Action Committee was held on February 14, 1986. The Trustees reviewed pending requests for funds and decided to make contributions on behalf of the Senatorial and Congressional candidates listed below in the amounts stated.

U.S. Senate

James Broyhill (R-NC)	$1,000.00
Robert Kasten (R-WI)	$ 500.00
Hensen Moore (R-LA)	$ 500.00
Paul Trible (R-VA)	$ 200.00

U.S. House

David Dreier (R-CA-33rd)	$ 250.00
Bill Gray (D-PA-2nd)	$ 500.00
Dick Gephardt (D-MO-3rd)	$ 500.00
Andy Ireland (R-FL-10th)	$ 500.00
Robert Matsui (D-CA-3rd)	$ 350.00
Bob Michel (R-IL-18th)	$ 250.00
John Porter (R-IL-10th)	$ 700.00
Charles Rangel (D-NY-16th)	$ 150.00
	$ 500.00
Robin Tallon (D-SC-6th)	$ 250.00
Bill Thomas (R-CA-20th)	$ 250.00

BAXPAC also contributed $2,000.00 to "Campaign America" which is a general Republican Senatorial campaign fund.

TOTAL CONTRIBUTIONS FOR 1986 $8,400.00

In addition, the Trustees reviewed the 1985 Year-End Treasurer's Report. This includes all contributions made to candidates in 1985 and the respective amounts.

1985 Year-End Treasurer's Report

1985 Year-End Treasurer's Report

U.S. Senate

Dale Bumpers (D-AK)	$ 2,000.00
Alan Dixon	$ 1,000.00
David Durenberger (R-MN)	$ 1,000.00
Orrin Hatch (R-UT)	$ 500.00
Robert Kasten (R-WI)	$ 1,000.00
Robert Packwood (R-OR)	$ 1,000.00
Charles Percy (Debt Retirement)	$ 500.00
Dan Quayle (R-IN)	$ 2,000.00
Paul Simon (D-IL)	$ 2,000.00
Arlen Specter (R-PA)	$ 500.00

U.S. House

Beryl Anthony (D-AK-4th)	$ 1,000.00
Jim Broyhill (R-NC-10th)	$ 500.00
Carroll Campbell (R-SC-4th)	$ 250.00
Bob Dornan (R-CA-38th)	$ 500.00
Webb Franklin (R-MS-2nd)	$ 250.00
Bill Frenzel (R-MN-3rd)	$ 500.00
Robert Garcia (D-NY-18th)	$ 500.00
Dick Gephardt (D-MO-3rd)	$ 500.00
Sam Gibbons (D-FL-7th)	$ 500.00
Judd Gregg (R-NH-2nd)	$ 250.00
Carroll Hubbard (D-KY-1st)	$ 350.00
Andy Ireland (R-FL-10th)	$ 350.00
Tom Kindness (R-OH-8th)	$ 1,500.00
Norman Lent (R-NY-4th)	$ 300.00
Trent Lott (R-MS-5th)	$ 500.00
Hensen Moore (R-LA-6th)	$ 250.00
Charles Rangel (D-NY-16th)	$ 1,500.00
Claudine Schneider (R-RI-2nd)	$ 250.00
Richard Shelby (D-AL-7th)	$ 300.00
Bob Smith (R-OR-2nd)	$ 550.00
Robin Tallon (D-SC-6th)	$ 250.00
Bill Thomas (R-CA-20th)	$ 500.00
Ron Wyden (D-OR-3rd)	$ 250.00

Other

The Fund For America's Future	$ 1,000.00
HIMAPAC	$ 600.00

TOTAL CONTRIBUTIONS FOR 1985 $24,700.00

As of March 3, 1986 the BAXPAC has $8,505.75 in available funds, and 283 participating members.

BAXPAC Trustees

John Noble, Chairman
Thomas W. Hodson, Treasurer
William Fenneily, Plant Advisory Chairman
G. Marshall Abbey
Fred Grossmann
Steve Kane
Roger F. Lewis

The Trustees welcome and encourage specific recommendations of federal candidates and campaigns from any active BAXPAC member. Please send suggestions, in writing, to BAXPAC Chairman John Noble at DF 1-2.

K

Posted: Thu Dec 19, 1985 3:34 PM PST Msg: JGIF-2339-7438
From: JRCARTER
To: NJBARTER
CC: JRCARTER
Subj: SENATOR DURENBERGER VISIT TO SPACE PARK

Senator Dave Durenberger (R-MN) December 19, 1985 J. Carter
Visit to Space Park

Distribution N. Barter AVA 2600/276-5120

Senator Durenberger (R-MN), Chairman of the Select Committee on Intelligence, will be visiting Space Park on Wednesday afternoon, January 8, 1986. The Senator will be given an overview of TRW, an overview of TRW's interest and involvement in SDI, and a briefing on procurement issues. Neville Barter is handling administrative arrangements for the visit.

TRW will be hosting a dinner for the Senator the evening of January 8 at the Sheraton La Reina Board Room. Cocktails begin at 6:30 and dinner at 7:00. Please let my secretary, Terri Eberly, know as soon as possible if you can attend. If you are unable to attend, please designate a substitute.

This is an idea opportunity to exchange views with the Chairman of the Senate Intelligence Committee, and I hope that each of you will be able to attend.

A copy of Congressman Fazio's biography will be forwarded via pouch mail.

DISTRIBUTION

G. Solomon YES
C. Stephens NO
B. Burnett NO
E. Dunford YES
R. North NO
R. Walquist-NO
R. Williams YES
F. Powell NO
J. Amato
G. Elverum YES
D. Goldin YES
P. Papaccio

W. Wellens - YES
N. Trembath YES
T. Wilson NO
H. Delmuro WC
J. Boone
F. Alexander - YES
T. Hanneman
D. Sullivan NO
R. Mulligan YES
J. Gray
[redacted]
M. Gorman - YES

ND

SPECIAL
COUNSEL
HEARING
EX. 196

A

PIRANHA

PRESS

Gary L. Diamond
Publisher

December 23, 1985

Mr. Jack Carter
1000 Wilson Blvd.
Suite 2600
Arlington, VA 22209

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Carter:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the TRW on January 8, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

B

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

C

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
January 8, 1986	2:00 p.m.	Puerto Rico	$2,000

D

Interoffice Correspondence
Electronics & Defense Sector

TRW

Subject: Honorarium

Date: December 24, 1985

From: J. R. Carter

To: R. Brown

cc:

Location/Phone: AVA 2600/276-5120

The following members of Congress will be visiting Space Park during the month of January, and I would like to offer honoraria as indicated. While at Space Park, the members will be briefed on a number of specific TRW programs and will address a group of senior TRW executives. The TRW programs to be briefed will vary depending on the member, but will include programs such as SDI, SAC Command Post, I-S/A AMPE, space programs, and procurement issues.

MEMBER	DATE	EVENT	HONORARIUM
Congressman Vic Fazio (D-CA)	Jan. 8	Large Group E2-Auditorium	$1,000
→ Senator Dave Durenberger (R-MN)	Jan. 8	Dinner at Sheraton LaReina	$2,000
Congressman Bill Hefner (D-NC)	Jan. 13	Dinner (TBD)	$1,000
Senator Thad Cochran (R-MS)	Jan. 15	Lunch at E2	$2,000
Congressman Joseph McDade (R-PA)	Jan. 20	Dinner at Sheraton LaReina	$1,000
Congressman Bill Young (R-FL) *	Jan. 17	TBD (most likely lunch)	$1,000

* in Colorado Springs

OK
J.R. Brown JAN 2
1/2/86

E

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- ONE MALL NORTH, COLUMBIA, MD. 21044 (301) 730-1500
- 8229 BOONE BLVD., SUITE 180, VIENNA, VA. 22180 (703) 790-0505
- 27801 EUCLID AVE., SUITE 240, EUCLID, OHIO 44132 (216) 261-0880

TRW ELEC & DEFENSE

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TRW INCORPORATED
1000 WILSON BLVD STE 2600
ARLINGTON VA 22209

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IF YOUR PLANS CHANGE ENROUTE OR WHEN OUR OFFICE IS CLOSED,
CALL 800-628-6668. YOUR V.I.T. CODE IS SY4X.
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DURENBERGER/DAVE SEN TKT # 0127789043650 $ 435.0
AMERICAN EXPRES #372018594241004 EXP 09/87 $ 435.0

TOTAL $ 0.0

Jack Carter
Los Angeles
Tuesday, January 7 - Thursday, January 9

Tuesday, January 7

4:30 p.m.	ATT Driver Requested Pick up at Carter Residence
5:20 p.m.	Depart Dulles/TWA 891, Row 10, Seat 2
8:00 p.m.	Arrive L.A.
RON	Sheraton La Reina Confirmation #883628139 642-1111

Wednesday, January 8

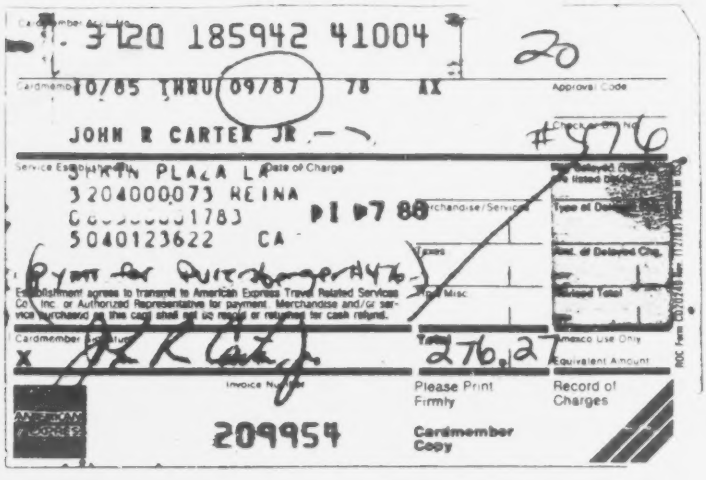
9:30 a.m.	Dick Friedman, DSP R5-1070 X57991
11:00 a.m.	Mavis Thruman 102-2144 X50866
p.m.	Briefings/Durenberger
Dinner 6:30-8:30	Sheraton La Reina Board Room Durenberger
RON	Sheraton La Reina

Thursday, January 9

9:00 a.m.	Depart L.A./TWA 890, Row 2, Seat 4
4:50 p.m.	Arrive Dulles/ATT Driver Requested To Carter Residence - Benefield Residence

HAVE A NICE TRIP

G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JOHN R CARTER JR
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3204000073 REINA
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Date of Charge
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Taxes
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Invoice Number
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H

Sheraton Plaza LaReina

DEPT 50584
6101 WEST CENTURY BOULEVARD
LOS ANGELES, CALIFORNIA 90088
(213) 642-1111

CH

ACCOUNT 145418 PAGE 01

DURENBERGER, SENATOR D
7732 CANAL CT
MCLEAN, VA 22102 ROOM 476

DATE 1986	CODE NO	TICKET NO	EXPLANATION	CHARGES	CREDITS
JAN06	551	00697	TELEPHONE=	.50	99
JAN06	141	59521	LANDRY'S	22.67	62 3
JAN06	551	00801	TELEPHONE=	.50	99
JAN06	011	00476	ROOM CHG	60.00	00
JAN06	011	00476	TAX-ROOMS	6.60	00
JAN07	551	00056	TELEPHONE=	.50	99
JAN07	421	00476	VALET	9.25	45
JAN07	551	00168	TELEPHONE=	.50	99
JAN07	011	00476	ROOM CHG	60.00	00
JAN07	011	00476	TAX-ROOMS	6.60	00
JAN08	551	00206	TELEPHONE=	.50	99
JAN08	551	00214	TELEPHONE=	.50	99
JAN08	111	29336	BRASSERIE	10.93	78 1
JAN08	551	00297	TELEPHONE=	.50	99
JAN08	551	00463	TELEPHONE=	.50	99
JAN08	421	00476	VALET	14.25	55
JAN08	551	00971	TELEPHONE=	.50	99
JAN08	011	00476	ROOM CHG	60.00	00
JAN08	011	00476	TAX-ROOMS	6.60	00
JAN09	551	00078	TELEPHONE=	.50	99
JAN09	551	00082	TELEPHONE=	.50	99
JAN09	551	00156	TELEPHONE=	.50	99
JAN09	111	29722	BRASSERIE	12.87	78 1
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JAN09	001	00001	AMEX	276.27CR	50
			TOTAL-DUE	.00	

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01/09/86
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I AGREE THAT MY LIABILITY FOR THIS BILL IS NOT WAIVED AND AGREE TO BE HELD PERSONALLY LIABLE IN THE EVENT THAT THE INDICATED PERSON, COMPANY OR ASSOCIATION FAILS TO PAY FOR ANY PART OR THE FULL AMOUNT OF THESE CHARGES

Guest's Signature _____

CHARGED TO _____

STREET _____

STATE _____

Visit of Senator Dave Durenberger (R-Minnesota)

January 8, 1986

E2 10th Floor Board Room

2:30	Arrival	
2:30-2:50	TRW Overview	Neville J. Barter Director, Communications S&TG
2:50-3:20	SDI Overview	Robert L. Walquist Vice President and SDI Program Executive E&DS
3:20-3:50	Procurement Issues	Dick Mulligan Vice President Government Procurement Policy E&DS
3:50	Depart	

BRIEFING FOR SENATOR DURENBERGER
JANUARY 8, 1986

583

R. G. MULLIGAN

AGENDA

I. USE OF COMPLETED CONTRACT METHOD OF ACCOUNTING FOR TAX PURPOSES

II. FRAUD, WASTE AND MISMANAGEMENT

III. PROGRESS PAYMENTS

IV. DIFFERENCES BETWEEN COMMERCIAL AND GOVERNMENT BUSINESS PRACTICES

PART I. COMPLETED CONTRACT METHOD OF ACCOUNTING (CCM)

Q. WHAT IS IT?

A. A METHOD OF ACCOUNTING (FOR TAX PURPOSES) IN WHICH TAXES ARE PAID ONLY AFTER THE CONTRACT IS COMPLETE AND THE ACTUAL PROFIT OR LOSS IS KNOWN.

Q. DOES IT RESULT IN REDUCING CONTRACTORS TAX LIABILITY LIKE A TAX DEDUCTION OR THE INVESTMENT TAX CREDIT DOES?

A. NO. UTILIZING CCM ONLY DEFERS THE PAYMENT OF THE TAX UNTIL IT CAN BE DETERMINED WITH REASONABLE ACCURACY.

Q. WHY IS IT DIFFICULT TO DETERMINE?

A. IT INVOLVES COMPLEX, COSTLY, CUSTOMIZED WORK, E.G.,COMMUNICATIONS SATELLITES.

Q. IS THIS SOME NEW TAX GIMMICK OR SHELTER?

A. NO. CCM HAS BEEN USED SINCE 1918 AND IN THE AEROSPACE INDUSTRY SINCE 1973.

Q. DOESN'T CCM GIVE CONTRACTORS A SPECIAL PREFERENCE OVER OTHER MANUFACTURERS?

A. NO. A MANUFACTURERER'S PROFITS ARE TAXED ONLY WHEN A SALE HAS BEEN COMPLETED. TAXES ARE NOT PAID RATABLY OVER THE PRODUCTION CYCLE.

Q. WHY THE EFFORT TO ELIMINATE IT?

A. TWO REASONS:

1) MISTAKEN BELIEF THAT IT WILL INCREASE TAX REVENUES - IT WON'T - ONLY ACCELERATE PAYMENT IN SOME CASES.

2) THERE WERE ABUSES AND SOME GOVERNMENT CONTRACTORS WERE PAYING LITTLE OR NO TAXES.

Q. WHAT KIND OF ABUSES?

A. SOME CONTRACTORS WERE KEEPING CONTRACTS OPEN TOO LONG, E.G., UNTIL DELIVERY OF THE LAST MANUAL OR DRAWING.

Q. HAVE THESE ABUSES BEEN CORRECTED?

A. YES. TEFRA II (1982) CURED THE ABUSES. DEFENSE CONTRACTORS ARE NOW PAYING TAXES MORE CURRENTLY.

Q. HOW DOES THE CURRENT HOUSE TAX BILL TREAT CCM?

A. IT ELIMINATES IT ON ALL CONTRACTS EXECUTED AFTER 9/25/85.

Q. WHAT WILL BE THE RESULT?

A. CONFUSION - INACCURATE ESTIMATES OF PROFITS - OVERPAYMENT OF TAXES - UNDERPAYMENTS ALSO POSSIBLE - CONSTANT YEAR-TO-YEAR ADJUSTMENTS, ARGUMENTS, LITIGATION, ETC.

Q. WHAT SHOULD THE SENATE DO?

A. RESTORE CCM ON CONTRACTS WHERE THE FINAL PROFIT CANNOT BE ACCURATELY DETERMINED UNTIL THE CONTRACT IS ESSENTIALLY COMPLETE.

Q. IF, FOR SOME REASON, THE SENATE CANNOT RESTORE CCM, IS THERE ANYTHING ELSE THEY COULD DO?

A. YES. INSIST THAT FOR TAX PLANNING PURPOSES THE EFFECTIVE DATE FOR ELIMINATION OF CCM BE MOVED FROM 9/25/85 TO 1/1/87.

PART II. THE DEFENSE INDUSTRY HAS NO MONOPOLY ON:

FRAUD, WASTE AND MISMANAGEMENT!

EXXON: (OVERCHARGES)

AMERICAN AIRLINES (INADEQUATE MAINTENANCE) - FINED $1.5M

CROCKER NATIONAL BANK (REPORTING VIOLATIONS)

E.F. HUTTON: (CHECK KITING)

ALL HAVE HAD SOME PROBLEMS IN THIS SAME AREA!

FRAUD, WASTE AND MISMANAGEMENT!!!

MANY "DEFENSE COMPANIES" ARE CONGLOMERATES WITH "**MIXED BUSINESSES**"

ROCKWELL INTERNATIONAL

WESTINGHOUSE

SPERRY

G.E.

TRW

BOEING

CLEARLY IF THERE WAS SOME MAGIC ABOUT COMMERCIAL BEING "**CLEANER**" WOULDN'T YOU EXPECT THESE MIXED CONGLOMERATES TO BE **CLEAN**?

590

THE DEFENSE INDUSTRY IS PROBABLY NO MORE OR NO LESS SUBJECT TO "F W & M" THAN OTHER COMPANIES.

BUT IT'S SUBJECT TO:

- CLOSER SCRUTINY
- MORE WHISTLE BLOWERS
- MORE AUDITORS
- MORE REGULATIONS

BECAUSE: DIRECT GOVERNMENT FUNDS ARE INVOLVED!

591

INVESTIGATIONS MADE BY THE GOVERNMENT AND INDUSTRY REVEAL THAT F W & M WAS SELDOM DONE TO "FATTEN A POCKET"

IT WAS DONE TO SUCCEED!!

- TO MAKE THE BUSINESS PROFITABLE!
- TO MAKE THE BUSINESS LOOK GOOD!
- TO AVOID A SELL-OFF OF BUSINESS
- TO MEET CORPORATE GOALS
- TO MEET INTERNAL BUDGETS

USUALLY HAPPENED IN SMALLER UNITS IN GEOGRAPHICALLY REMOTE AREAS (REMOTE FROM HOME OFFICE CONTROL). HOWEVER, THE ENTIRE COMPANY IS "TAINTED WITH THE BRUSH."

592

PART III. PROGRESS PAYMENTS

PROGRESS PAYMENTS ARE MADE AGAINST COSTS INCURRED

SINCE THE GOVERNMENT AUDITS OUR COSTS,

THEY PAY 80%, 85% OR 90% OF THOSE COSTS

AS THE WORK PROGRESSES

THE PERCENTAGE IS SET BY THE DEPARTMENT OF DEFENSE

593

IF THE GOVERNMENT DIDN'T ADVANCE THESE FUNDS,

WE'D HAVE TO BORROW THEM!

AND THE PRICES WOULD GO UP!

SINCE THE CUSTOMER (GOVERNMENT) WILL PAY EITHER WAY,

THE REAL ISSUE IS WHO CAN BORROW

THE MONEY AT THE LOWEST COST?

THE ANSWER IS OBVIOUS - THE GOVERNMENT CAN!

THE RECENTLY COMPLETED DFAIR STUDY RECOMMENDS:

1. THAT PROGRESS PAYMENT RATES SHOULD FLOAT WITH THE INTEREST RATE

2. THAT THE CURRENT RATE SHOULD BE 85%, NOT 80%

WE THINK THAT'S FAIR!

ABOVE ALL, WE DON'T LIKE: THE RECENT WAVE OF YO-YOING, KNEE-JERK REACTION CHANGING OF THESE RATES

IT PLAYS HAVOC WITH AN ATTEMPT AT REASONABLE FINANCIAL PLANNING!

595

PART IV. SOME MAJOR DIFFERENCES BETWEEN COMMERCIAL AND GOVERNMENT DEFENSE BUSINESS PRACTICES

- PRODUCT DEMONSTRATION, I.E., DISPLAY AT THE PARIS AIR SHOW
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - UNALLOWABLE COST
- PRODUCT ADVERTISEMENT, I.E., TRADE MAGAZINES AND SHOWS
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - UNALLOWABLE COST
- CUSTOMER ENTERTAINMENT, I.E., WINE'EM AND DINE'EM
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - UNALLOWABLE COST - POSSIBLY ILLEGAL
- HIRING CUSTOMER'S EX-EMPLOYEE - IF YOU CAN'T BEAT'EM--JOIN'EM
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - YOU'RE INVOLVED IN A REVOLVING DOOR

- WARRANTIES
  - COMMERCIAL: - OFTEN USED TO PROMOTE AFTER-DELIVERY SALES
    THE 18-MONTH BATTERY REFUND (REPAIR, REPLACE OR CREDIT)
  - DEFENSE: - OFTEN UNREALISTIC FOR ONE-OF-A-KIND PRODUCTION
    MAXIMUM RELIABILITY **MUST** BE BUILT INTO THE ORIGINAL PRODUCTION
    PAYMENT INCENTIVES REVOLVE AROUND RELIABILITY

- PLANNING OBSOLESCENCE - DON'T MAKE IT WORK TOO LONG
  - COMMERCIAL: - SHARP BUSINESS PRACTICE
  - DEFENSE: - CONTRARY TO PUBLIC POLICY, WE **NEED** THE **BEST** WE CAN MAKE

- MAKING EXCESSIVE PROFIT - WILL MAKE IT UP ON BLADES AND REPLACEMENTS
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - A RIP-OFF AND ABUSE

- DISCOVERING ILLEGAL EMPLOYEE PRACTICE
  - COMMERCIAL: - DISCHARGE EMPLOYEE
  - DEFENSE: - CHARGE THE COMPANY WITH FRAUD AND DEBAR THE COMPANY

- IR&D AND PRODUCT DEVELOPMENT
  - COMMERCIAL: - THE COST IS FULLY RECOVERED
  - DEFENSE: - PARTIAL (70-75%) RECOVERY AND EVEN THE PARTIAL RECOVERY IS UNDER ATTACK

597

- PROVIDE EXECUTIVES WITH PERKS
  - COMMERCIAL: - GOOD BUSINESS PRACTICE
  - DEFENSE: - RIPPING OFF THE TAXPAYER

- SETTING PRICES
  - COMMERCIAL: - WHAT THE MARKET WILL BEAR
  - DEFENSE: - NEGOTIATED AFTER COMPLETE COST REVIEW

- GOVERNMENT AUDIT OF BOOKS
  - COMMERCIAL: - I.R.S. ONLY ON A LIMITED BASIS
  - DEFENSE: - COMPLETELY OPEN TO AUDIT, INCLUDING D.C.A.A., G.A.O., I.G., AF PLANT REP

- ACCESS TO RECORDS
  - COMMERCIAL: - NO
  - DEFENSE: - YES

- REGULATIONS
  - COMMERCIAL: - LIMITED
  - DEFENSE: - MOST REGULATED INDUSTRY - DAR, FAR, CASB, SOCIO-ECONOMIC CONTRACT CLAUSES CICA, PL-87-653, PL-91-441, ETC., ETC.

THERE ARE A COUPLE OF OLD DEFENSE INDUSTRY SAYINGS:

- THE ONLY THING WORSE THAN A DEFENSE CONTRACT - IS NO DEFENSE CONTRACT.

AND LIKE SEX

- WHEN THE DEFENSE BUSINESS IS GOOD, IT'S VERY, VERY GOOD!
  WHEN THE DEFENSE BUSINESS IS BAD, IT'S STILL PRETTY GOOD!

599

AA

600

2081263 081263

TRW

TRW Inc.
Electronics &
Defense Sector

One Space Park
Redondo Beach, CA 90278

88 2149
1149

Texas Commerce Bank
P. O. Drawer 140
Corpus Christi, Texas 78403

CHECK DATE

3 13 86

CHECK AMOUNT

****2,000

PAY ****2,000 DOLLARS AND 00 CENTS

$ ****2,000.00

TO THE ORDER OF

SEN. DAVE DURENBERGER
UNITED STATES SENATE
WASHINGTON

PAID
MAR 24 86
TEXAS COMMERCE BANK
CORPUS CHRISTI, TX
88-2149

DISBURSING ACCOUNT

D. Saiki

⑈2081263⑈ ⑆114921⑆ ⑈18⑆ 2⑈ ⑆0000200000⑈

BB

Pay to Piranha Press
Sen. Dave Durenberger

PAY TO THE ORDER OF
NORWEST BANK MIDLAND, N.A.
ST. LOUIS PARK, MN
FOR DEPOSIT ONLY
PIRANHA PRESS, INC.
320 04 346

cc

TRW

TRW Inc.
Electronics &
Defense Sector

Washington Office
1000 Wilson Blvd., Suite 2600
Arlington, VA 22209
703 276 5100

Bruce Benefield
Vice President

January 22, 1986

The Honorable Dave Durenberger
U. S. Senate
Washington, DC 20510

Dear Senator Durenberger:

On behalf of TRW's Electronics and Defense Sector, I am pleased to enclose a check for $2,000 as an honorarium covering your recent presentation at Space Park.

We thoroughly enjoyed having you with us and appreciate the candor of your remarks at our Management dinner. Your comments were timely and helpful to us as we plan ahead for 1986.

Again, many thanks. Wishing you the very best,

Bruce

Enclosure

2081263 081263 TRW TRW Inc. Electronics & Defense Sector One Space Park Redondo Beach, CA 90278

88-2142
1149

Texas Commerce Bank P. O. Drawer 140 Corpus Christi, Texas 78403

CHECK DATE 1 13 86 CHECK AMOUNT ****2,00000 $

PAY ****2,000 DOLLARS AND 00 CENTS

TO THE ORDER OF SEN. DAVE DURENBERGER
UNITED STATES SENATE
WASHINGTON DC 20510

DISBURSING ACCOUNT
Saiki CONTROLLER

⑈2081263⑈ ⑆114921499⑆ ⑈18⑈ 712⑈

DD

Lockheed Corporation

Burbank, California 91520

January 30, 1986

Mr. Jack Carter
TRW, Inc.
1000 Wilson Blvd., #2700
Arlington, VA 22209

Dear Jack:

Enclosed is our reimbursement for a portion of Senator Durenberger's travel expense.

Thank you for handling the expense.

Sincerely,

Steve

Steve Chaudet

Enclosure

EE

Interoffice Correspondence
Electronics & Defense Sector

TRW

Subject	Date	From
CONGRESSIONAL VISIT TRIP REPORT	January 31, 1986	J. R. Carter
To	**cc**	**Location/Phone**
MEMORANDUM FOR THE FILE	B. Benefield D. O'Neill B. Wright H. Steenstra	AVA-2600/276-5120

I. **MEMBER/STAFF VISITING TRW FACILITY:**

Senator Dave Durenberger, January 7-9, 1986

II. **PURPOSE OF VISIT:**

Overview of TRW, TRW's interest and involvement in SDI, and briefing on procurement issues

III. **AGENDA:**

Dinner reception, Sheraton LaReina Board Room. List of attendees attached.

IV. **HONORARIUM:**

$2,000

V. **TYPE OF FUNCTION FOR HONORARIUM/TRW REPRESENTATIVES IN ATTENDANCE:**

Dinner/Sheraton Plaza La Reina Hotel

Eighteen TRW representatives, see attached list.

VI. **FOLLOW-UP ACTION/COMMENTS:**

The Senator did not volunteer to lead the band on CCM, and in fact, may not even attend the Senate mark-up session. Predicted the Senate would end up accepting House tax bill with little change. Got Mulligan's message on delay in implementation of new CCM rules, and may help here--but I am not sure he will. Walquist did a good job on SDI. No viewgraphs, just a sit down discussion

FF

SYSTEMS 6066

Attendees - Dinner - January 8, 1986 - Sheraton Lareina Board Room

George Solomon	-	Executive Vice President and General Manager Electronics and Defense Sector
Ed Dunford	-	Vice President and General Manager TRW Space and Technology Group
Gordon Williams	-	Vice President and Director - Group Development TRW Space and Technology Group
Gerry Elverum	-	Vice President and General Manager Applied Technology Division
Dan Goldin	-	Vice President and Program Manager MILSTAR Payload Program Military Electronics Division
Joseph Wellens	-	Vice President and General Manager Military Space Systems Division
Nat Trembath	-	Vice President and Assistant General Manager for Programs TRW Defense Systems Group
Ted Wilson	-	Vice President - Financial Control Electronics and Defense Sector
James Boone	-	Director, Program Management and Group Development TRW Electronic Systems Group
Fred Alexander	-	Vice President and General Manager Electronic and Technology Division
Dick Mulligan	-	Vice President - Government Procurement Policy Electronics and Defense Sector
Mike Gorman	-	Vice President and General Manager Ballistic Missiles Division
Bruce Benefield	-	Vice President - Washington Office Electronics and Defense Sector
Jack Carter	-	Director, Congressional Relations - Washington Office Electronics and Defense Sector
Malcom Davis	-	Operations Manager - EDO
Chuck Hawn	-	Project Development Manager - Defense Projects Division
Ed Nowocki	-	" " TRW
Senator Danforth	-	United States Senate
Alden Munson	-	System Development Division TRW

GG

9/12

Chamber of Commerce of the United States

BUSINESS-GOVERNMENT POLICY DEPARTMENT
EMPLOYER RELATIONS SECTION

202-463-5514

1615 H STREET, N.W.
WASHINGTON, D.C. 20062

May 20, 1985

6/5
lunch is open

The Honorable David Durenberger
Chairman, Subcommittee on Health
Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger,

On behalf of the U.S. Chamber of Commerce, I am writing to inquire whether you would be available to address our Health Care Committee at its next meeting on June 5. The meeting will be held at the Capital Hilton, at 16th and K Streets, in the Pan American Room. We would like you to speak at the luncheon, concerning health care legislation in the 99th Congress.

The Health Care Committee is the U.S. Chamber body that originates recommendations on Chamber policy. It is drawn from a representative cross-section of our membership.

I already have discussed this meeting with Chip Kahn, and I will be in touch with your appointments secretary regarding your availability. Please do not hesitate to have your staff contact me at 463-5514 if I can provide any further information.

Many thanks in advance for your favorable consideration of this request.

Sincerely,

Eric J. Oxfeld/jgs

Eric J. Oxfeld

EJO:jgs

cc: Chip Kahn
Anne Kelly

Sym/Dong
FYI next one will be in fall - DD wants to do it.
Keep in Open Scheduling file.

Eric will call.

SPECIAL COUNSEL HEARING EX. 197

A

July 1d, 1985

The Honorable Dave Durenberger
United States Senate
147 Russell Senate Office Building
Washington, D. C. 20510

Dear Senator Durenberger:

On behalf of the U.S. Chamber of Commerce, I would like to [illegible] to participate in our Corporate Executive Development Program, [illegible] INSIGHT ON EMPLOYEE BENEFITS. This is a luncheon session scheduled for [illegible], October 7, 1985, from 12:15 to 2:00 p.m., in the Executive Suite of the Capitol Quality Inn.

For your information and background, I have enclosed the [illegible] describes the program and its objectives and includes highlights of last year's program. This will provide you a thorough view of the types of activities that take place during the week.

The October 6 - 10, 1985 program will be attended by 20 - 30 corporate benefits executives. They will be in town for one week of off-the-record meetings and discussions designed to help them understand the operations, policies and programs of the federal government in the benefits policy area, as well as the role of non-governmental groups that operate here. As chairman of the Senate Finance Committee's Health Subcommittee, we feel your participation would be of vital importance to this program.

After a brief reception and lunch, I would like you to share your views on current and proposed changes in U.S. tax policy that directly affect the health benefits area, and share some of your perspectives regarding the [illegible] cost containment generally. I also would like you to [illegible] your views on the congressional policymaking process [illegible] of the of the difficulties and political pressures you [illegible] of a Senate subcommittee. Please plan to allow [illegible] minutes for questions and discussion. Ideally, we would like you to [illegible] for the entire period, including the reception and lunch. However, if your schedule does not permit you to be with us for the entire time, we would appreciate your being able to join us for one hour to be able to share your views with our participants — either 12:15 to 1:15 p.m., or 1:00 to 2:00 p.m. Let me emphasize that the session is informal and off-the-record.

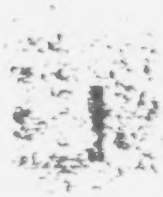
B

For your participation, we will be pleased to present you with an honorarium of $500.

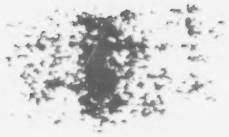
Thank you, and I look forward to hearing from you at your earliest convenience. Should you have any questions, please don't hesitate to get in touch with either me or Nancy Turnbull.

Sincerely,

Suzanne J. Lalewicz
Associate Director



Enclosure



C

WASHINGTON INSIGHT ON EMPLOYEE BENEFITS

October 6 - 10, 1985

Sunday, October 6

4:00 - 4:15 p.m.	Coffee (Conference Rooms 1 & 2, U.S. Chamber Building, 1615 H Street, N.W.)
4:15 - 5:00 p.m.	Welcome and Orientation to the Program and the U.S. Chamber of Commerce (Conference Rooms 1 & 2) Suzanne Lulewicz, Associate Director, Specialized CED Programs, U.S. Chamber of Commerce
5:00 - 6:00 p.m.	Introduction to the Politics of Washington -- A Journalist's View (Conference Rooms 1 & 2) Elizabeth Drew, Syndicated Columnist
6:00 - 6:45 p.m.	How Congress Operates (Conference Rooms 1 & 2) James Klein, Manager, Pensions & Employee Benefits, Business-Government Policy Department, U.S. Chamber of Commerce
6:45 p.m.	Depart for Trader Vic's
7:00 p.m.	Role of Congressional Staff (Trader Vic's, Marco Polo Room, Capitol Hilton Hotel, 16th & K Streets., N.W.) Reception and Dinner with Phyllis Borzi, Counsel for Pensions, House Subcommittee on Labor-Management Relations

Monday, October 7

8:00 - 8:30 a.m.	Continental Breakfast (Conference Rooms 1 & 2, U.S. Chamber Building)
8:30 - 9:30 a.m.	The Media's View of Washington (Conference Rooms 1 & 2) George Herman, CBS News
9:30 - 9:45 a.m.	Coffee Break
9:45 - 11:30 a.m.	Employee Benefits Overview: Issues, Policies and Personalities (Conference Rooms 1 & 2) Panel of Chamber Benefits Staff Specialists: James Klein, Manager, Pensions and Employee Benefits and Eric Oxfeld, Manager, Health Care and Employee Benefits, Business-Government Policy Department, U.S. Chamber of Commerce
11:45 a.m.	Depart for Capitol Hill

D

12:15 - 2:00 p.m.	Dialogue with a Senator (Council Suite, Capitol Quality Inn, 415 New Jersey Avenue, N.W.) Reception and luncheon with Senator Dave Durenberger (R-Mn.), Chairman of the Finance Committee's Subcommittee on Health
2:00 p.m.	Depart for the Internal Revenue Service, 1111 Constitution Avenue, N.W.
2:30 - 3:30 p.m.	Internal Revenue Service (Room 3313) James J. McGovern, Director of Employee Plans & Exempt Organizations, Office of the Chief Counsel; William Posner, Special Assistant, Employee Plans; Richard Wickersham, Chief, Branch 1, and Michael Thrasher, Chief, Branch 2, Employee Plans & Exempt Organizations Division, Internal Revenue Service
3:30 p.m.	Depart for the Department of Treasury (15th Street & Pennsylvania Avenue, N.W.)
4:00 - 5:00 p.m.	Department of Treasury's Office of Tax Policy (Conference Room 4426) Harry Conaway, Attorney-Advisor, Office of Tax Legislative Counsel, Department of the Treasury
5:00 p.m.	Depart for the U.S. Chamber Building

EVENING FREE FOR PARTICIPANTS

Tuesday, October 8

8:00 - 8:30 a.m.	Continental Breakfast (Conference Rooms 1 & 2, U.S. Chamber Building)
8:30 - 9:30 a.m.	Department of Health & Human Services (Conference Rooms 1 & 2) Dr. Robert B. Helms, Acting Assistant Secretary for Planning and Evaluation, Department of Health & Human Services
9:30 - 9:45 a.m.	Coffee Break
9:45 - 10:45 a.m.	Role of a Trade Association (Conference Rooms 1 & 2) Geza Kadar, Jr., Assistant Washington Counsel, Health Insurance Association
10:45 a.m.	Depart for AFL-CIO Building, 815 16th Street, N.W.
11:00 - 12:00 noon	Meet with the AFL-CIO (Executive Council Room) Bert Seidman, Director, Department of Occupational Health, Safety and Social Security, AFL-CIO
12:00 noon	Depart for Luncheon

12:15 - 2:00 p.m.	The Role of the Corporate Representative in Washington (Sheraton Carlton Hotel, Chandelier Room, 16th & K Streets, N.W.) Luncheon with A. J. Harris, Vice President, Cigna Corporation
2:00 p.m.	Depart for the U.S. Chamber
2:15 - 3:15 p.m.	A Look at ERISA (Conference Rooms 1 & 2) Morton Klevan, Deputy Administrator, Pension and Welfare Benefit Programs, Department of Labor
3:15 - 3:30 p.m.	Coffee Break
3:30 - 4:30 p.m.	Talk with Pension Benefit Guaranty Corporation (Conference Rooms 1 & 2) Dr. Kathleen P. Utgoff, Executive Director
4:30 - 4:45 p.m.	Coffee Break
4:45 - 5:45 p.m.	Meet with the Equal Employment Opportunity Commission (Conferences Rooms 1 & 2) Stuart Frisch, Acting Associate Legal Counsel, Equal Employment Opportunity Commission
5:45 p.m.	Depart for International Club
6:00 p.m.	The Politics of Economics (Board Room, International Club, 18th & K Streets, N.W., 18th Street Entrance) Reception and dinner with Dr. William Orzechowski, Economic Policy Division, U. S. Chamber of Commerce

Wednesday, October 9

8:00 - 8:30 a.m.	Continental Breakfast (Conference Rooms 1 & 2, U.S. Chamber Building)
8:30 - 9:30 a.m.	Office of Management and Budget (Conference Rooms 1 & 2) Fred Upton, Director, Legislative Affairs, Office of Management and Budget
9:45 a.m.	Depart for Capitol Hill
10:15 - 12:00 noon	Attend Congressional Hearings
12:00 noon	Depart for Lunch
12:15 - 2:00 p.m.	The Member of Congress: Responsibilities and Pressures (Private Dining Room 3, Capitol Hill Club, 300 First Street, S.E.) Reception and luncheon with Representative Willis D. Gradison, Jr. (D-Tx.), Member of the House Ways & Means and Budget Committees
2:00 p.m.	Depart for Congressional Appointments

F

2:15 - 2:45 p.m.	Appointments with your Home District Representative & Staff
3:00 p.m.	Depart for Congressional Budget Office
3:15 - 4:15 p.m.	The Congressional Budget Office Nancy Gordon, Assistant Director, Human Resources and Community Development, Congressional Budget Office
4:15 p.m.	Depart for U.S. Chamber Building
4:30 - 5:30 p.m.	Congressional Research Service (Conference Rooms 1 & 2) Ray Schmitt, Specialist in Social Legislation Congressional Research Service

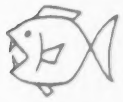
EVENING FREE FOR PARTICIPANTS

Thursday, October 10

8:00 - 8:30 a.m.	Continental Breakfast (Conference Rooms 1 & 2, U.S. Chamber Building)
8:30 - 11:00 a.m.	Influencing Public Policy Decisions Through Corporate Action Programs
8:30 a.m.	Mobilizing the Chamber's Membership Opinion at the Grass Roots (Conference Rooms 1 & 2) John Meehan, Vice President, Corporate Relations U.S. Chamber of Commerce
9:15 a.m.	Coffee Break
9:30 a.m.	How to Influence the Political Process (Conference Rooms 1 & 2) David Michael Staton, Manager, Political Action Programs, U.S. Chamber of Commerce
10:45 - 11:00 a.m.	Coffee Break
11:00 - 12:00 noon	Role of the Financial Accounting Standard Board (Conference Rooms 1 & 2) Patricia Pride, Manager, Government Affairs, Financial Accounting Standards Board
12:00 noon	Depart for Luncheon
12:15 - 2:15 p.m.	Employee Benefits: A Future Perspective (Chesapeake Room, Sheraton-Carlton Hotel, 16th & K Streets, N.W.) Henry Aaron, Senior Fellow, Brookings Institution
2:15 p.m.	Review and Wrap-up (Chesapeake Room, Sheraton-Carlton Hotel) Don Kroes, Vice President, Federation Development & Field Operations, U.S. Chamber of Commerce

G

PIRANHA



PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Ms. Suzanne Lulewicz
U.S. Chamber of Commerce
Corporate Executive Development
1615 H Street Northwest
Washington, DC 20062

FROM: PIRANHA PRESS

DATE: OCTOBER 9, 1985

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

We wish to advise you that Senator Durenberger has entered into an exclusive arrangement with us under which we must consent to his appearance and agree to the fees and expenses for any such appearance. Under our arrangement, you will be contacted by the law firm which represents Senator Durenberger for purposes of clarifying this arrangement and the fees to be paid.

If you have any questions, please contact Senator Durenberger's office or Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.
Kitty Gamble
Anne Kelly

10/21 - requested Sen. Durenberger's office (Jody Matheson, appt. secy.) to send us Sen. Durenberger's request in writing to pay his honorarium to Piranha Press

4504 EXCELSIOR BLVD · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

H

S. L

Chamber of Commerce of the United States of America

Washington

October 11, 1985

TO: ACCOUNTING

Please process honoraria checks for the following individuals who participated in the CED Program on Employee Benefits for the week of October 6th. Charge these to CED honoraria account #65070-324232.

Elizabeth Drew Inc. (SSN 521-18-4712)	$1,500
George Herman CBS News (SSN005-16-9035)	$ 500
The Honorable Dave Durenberger United States Senate (SSN 472-36-4210)	$ 500
The Honorable Bill Gradison U.S. House of Representatives (SSN 273-24-7837)	$ 400
Dr. Henry Aaron Brookings Institution (SSN 550-48-4730)	$ 500

Please call Irene Frey when checks are ready (X5733). We will handle mailing.

Thank you.

Nancy R. Turnbull

I

United States Senate

WASHINGTON, D.C. 20510

11/25/85
Chron 468

October 29, 1985

Ms. Suzanne Lulewicz
U.S. Chamber of Commerce
1615 "H" Street, Northwest
Washington, D.C. 20062

11/5/85
Chron 475

Dear Suzanne:

This letter is in regard to the stipend involved in the October 7, 1985 remarks to the U.S. Chamber of Commerce Employee Benefits group.

Please make the check out to **Pirahna Press** and send to **4504 Excelsior Blvd., Minneapolis, Minnesota 55416.**

Thank you for your assistance in this matter.

Sincerely,

Dave Durenberger
United States Senator

0510-352382
$500.00

DD/jlm

J

Chamber of Commerce of the United States of America

Washington

TO: General Accounting

DATE: 1/27/86

SUBJECT: Stop Payment

Please issue a stop payment on the check listed below. Once stop payment has been made, please notify us when a replacement check can be issued.

Account No. 3-008-789

Check No. 106080

Check Date 11-6-85

Check Amt. $500.00

Payable to PIRANHA PRESS

APPROVED BY _____

check stopped + confirmed
1-27-86
[illegible]

K

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA/Washington, D.C.

1ST AMERICAN FIRST AMERICAN BANK, N.A., WASHINGTON

ALSO PAYABLE WITHOUT EXCHANGE AT THE CHASE MANHATTAN BANK, N.A. OR BANK OF AMERICA, CALIF.

CHECK NO. 106080

FIVE HUNDRED DOLLARS NO CENTS

PAY TO THE ORDER OF
PEDANCA PRESS
4514 EXCELSIOR BLVD.
MINNEAPOLIS MN 55416

DATE 11-06-85

CHECK AMOUNT ******500.00

NON-NEGOTIABLE

AUTHORIZED SIGNATURE

⑈106080⑈ ⑆054000043⑆ ⑈3 008 789⑈

CHAMBER OF COMMERCE OF THE UNITED STATES/Washington, D.C.

DATE 11-06-85

CHECK NO. 106080

DATE	INVOICE OR CREDIT MEMO NUMBER	TYPE	DESCRIPTION	REFERENCE NO.	AMOUNTS GROSS	AMOUNTS DISCOUNTS	NET
10/29/85	103		DURENBERGER	40 110585	50000		50000
				TOTAL ▶	50000		50000

THE ATTACHED CHECK IS IN PAYMENT FOR ITEMS DESCRIBED ABOVE

617

from
Kalanka Press (2nd check)
$500.00 check # 106080
11/6/85

Nuremberger's 1st check was voided

1/3 400
Fabricfacts

Mailed 5358 1/22 stop payment to be issued a new check per request

[redacted]

Chamber of Commerce of the United States of America
Washington

November 1, 1985

DAVE MIMM

Dave, I'm enclosing a check made payable to Senator Dave Durenberger, in the amount of $500. This was his honorarium for speaking to our Corporate Executive Development Program on Employee Benefits on Monday, October 7th.

Attached is a letter from him, asking that the honorarium be paid to an organization called "Piranha Press" and sent to their address in Minneapolis. I would appreciate it if you would provide us with a new check. Please let me know if there are any problems with this. I've also attached some background correspondence.

Suzanne J. Lulewicz

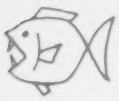
P.S. Please send the check to me. I will mail. Thanks.

cc: Bruce Brown
w/ atts.

N

620

PIRANHA



PRESS

Gary L. Diamond
Publisher

January 15, 1986

Ms. Suzanne Lulewicz
U.S. Chamber of Commerce
Corporate Executive Development
1615 H Street N.W.
Washington, DC 20062

RE: SPEAKING ENGAGEMENT BY SENATOR DAVE DURENBERGER

Dear Ms. Lulewicz:

In connection with Senator Durenberger's appearance before your group on October 7, 1985, you were to make payment in the amount $500 to the undersigned. Our records indicate that this amount has not been paid. We would appreciate payment as soon as possible.

If payment has been made, please disregard this letter.

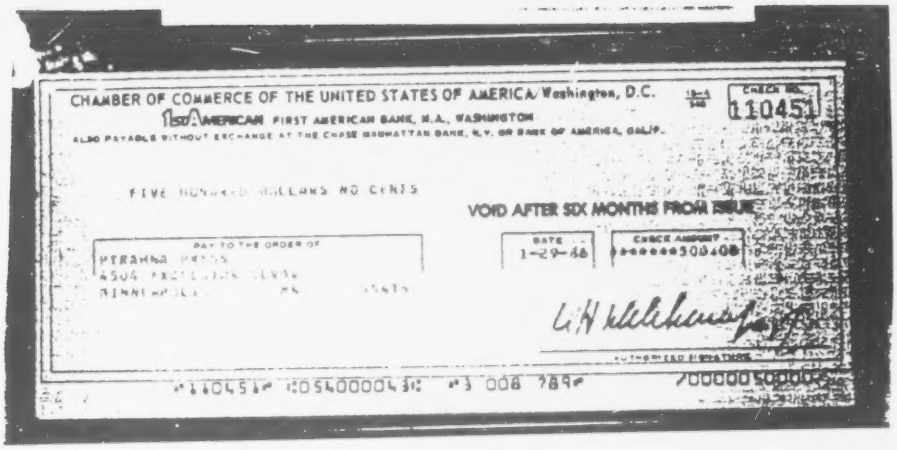
Very truly yours,

GARY L. DIAMOND

Called 1/22/86
check sent - not cashed
stop payment & send another

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

O



CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA/Washington, D.C.

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PIRANHA PRESS

4504 [illegible]

MINNEAPOLIS MN [illegible] STATES

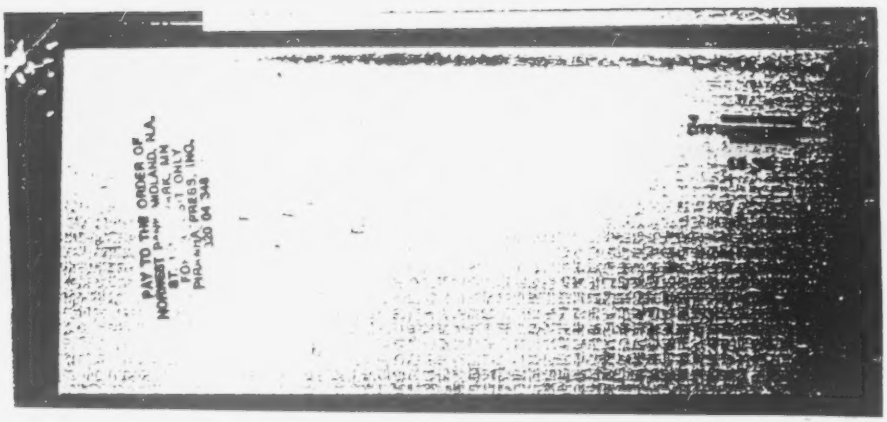
DATE 1-29-46

CHECK AMOUNT ******500.00

G.H. Hutchinson

AUTHORIZED SIGNATURE

⑈110451⑈ ⑆054000043⑆ ⑈3 008 789⑈ 700000 500000


PAY TO THE ORDER OF
MIDLAND, N.J.
-AK, MN
-21 ONLY
PRESS, INC.
100 04 348

SCHEDULING INFORMATION

SPEECH — TYPE OF EVENT
10/11/36 — EVENT DATE/TIME
all day conf. [last years conf ran 8-5:00]
* Homecoming U of M Check times
* Check flights
CFO

U.S. Health Corporation (Ohio's largest for profit multi-hospital system) — GROUP NAME

SPEECHES
Group Size ~300
Honorarium $5K OK'd by Ann 6/13/86 (amount)
Plus travel
Room Set-Up
Introduction by Eric Thapar
Taped _____ (y/n) Broadcast PRES & CEO (y/n)

Contact Anne Klie or Alison Lennon
Phone 614-261-5106
Key People

Topic Washington update on health care legislation trends tax reform affecting hospitals & health care

POLLOW-UP
Thanks Sent 10/14/86 Drafted
(date)
Photo _____ (y/n) Sent _____ (date)
Photo to Media _____ (date)

LOCATION OF EVENT Columbus, OH
Place Columbus Hyatt Regency
Room
Phone Number Hyatt Regency
Directions

Membership Lists
Received _____ (y/n)
Computerized _____ (y/n)
Filed _____ (y/n)
Regret Sent
Greeting Sent

Bill Address:
Ann Klie
Corporate Development
Riverside Methodist Hosp.
3555 Olentangy River Rd.
Columbus, OH
43214

STAFFING
Briefing Memo
Photo
Speech

MISCELLANEOUS
SPECIAL COUNSEL HEARING EX. 198
U of M Homecoming 7:30 PM
A

6/3/86
REQUEST DATE

Dinner of? ← Bill Wilkin {U.S. Healthcare Ex VP
→ to meet a gate -

RIVERSIDE METHODIST HOSPITAL

Steven J. Gu

June 3, 1986

Senator ~~Richard~~ Dave Durenberger
c/o Jodi Mathison
Russell Building - Room 154
Washington, D.C. 20211

Dear Senator Durenberger

You are invited to give a presentation October 11 in Columbus, Ohio at a health care retreat sponsored by U.S. Health Corporation, Ohio's largest nonprofit multi-hospital system.

More than 300 Ohioans are expected at the meeting. Attendees will include administration, board members and medical staff leadership from 1,092-bed Riverside Methodist Hospital in Columbus and the six other U.S. Health hospitals. Invited guests will also include representatives from Voluntary Hospitals of America-Central, the Ohio Hospital Association and the leadership from about 10 other hospitals from throughout Ohio.

I would like you to speak for about an hour and to provide a Washington update on health care legislation and trends.

I look forward to hearing about your availability. At that time, we can discuss your honorarium and fees.

I'm enclosing a packet of information about U.S. Health Corporation. If you need additional information, please don't hesitate to contact me.

Best wishes

Anne Klie

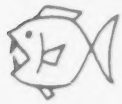
Anne Klie
Assistant to the Vice President
Corporate Development

AK/apc
Enclosure

6/10 Jody, booking assistant
$5,000, plus travel
She hopes he can
Jon us. Will call
in a few weeks

B

PIRANHA



PRESS

Gary L. Diamond
Publisher

M E M O R A N D U M

TO: Ms. Anne Klie
Assistant to Vice President
Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, OH 43214

FROM: PIRANHA PRESS

DATE: JULY 31, 1986

RE: SPEAKING ENGAGEMENT OF SENATOR DURENBERGER

We have received information from Senator Dave Durenberger's office that you have requested an appearance by him before your organization.

We wish to advise you that Senator Durenberger has entered into an exclusive arrangement with us under which we handle the arrangements for his appearances. You will be contacted by the law firm which represents Senator Durenberger for purposes of discussing fees and final arrangements for his appearance.

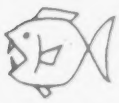
If you have any questions, please contact Senator Durenberger's office or Michael C. Mahoney, Esq., at (612) 333-5411.

cc: Michael C. Mahoney, Esq.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

PIRANHA



PRESS

Gary L. Diamond
Publisher

August 11, 1986

Ms. Anne Klie
Assistant to Vice President
Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, OH 43214

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Ms. Klie:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the U.S. Health Corporation on October 11, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

D

Ms. Anne Klie
Assistant to Vice President
Riverside Methodist Hospital
August 11, 1986
Page 2

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

E

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
October 11, 1986	8:15 a.m.	Columbus, OH	$5,000

3-11

Dear N -

Please call Judy in DAVE's office to get info to book his flight from Chicago. His contract states that we make (pay for) the travel arrangements -

~~If it is convenient~~ We hope he'll come in for the day. If he does we'll try to set up a dinner with [illegible], S.G + others.

Thanks -

AK

Mrs.

~~Please call Judy to book~~ arrangements

when he'd like to get into Chi - Ask what time he needs to be in Chicago -

~~Call agency for travel plans~~

G

, OR SUGGESTED VENDOR

RIVERSIDE METHODIST HOSPITAL
PURCHASE REQUISITION
FOR PURCHASING DEPT. USE ONLY

K

Piranha Press VENDOR NO. P.O. NUMBER

PAY TERMS P.O. DATE

SHIP VIA DELIVERY DATE

FOR DATE REQUIRED ASAP CHARGE TO ACCT. NO. DELIVER TO

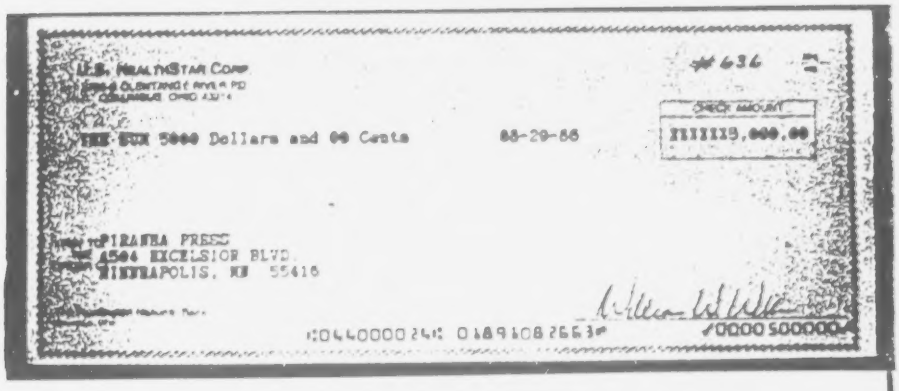
APPROVED BY ADM. APP.

CATALOGUE NO.	DESCRIPTION	PRICE
	Dave Duerenberger	
	Dues Hotel expenses	

RETAINER COPY - DETACH BEFORE SENDING P.O.

H

DATE	DOCUMENT	DESCRIPTION	ACCOUNT #	AMOUNT	DISC	NET
3-19-86	PIRAÑHA	PIRAÑHA/SEMINAR	5695.1000	5000.00	0.00	5000.00



U.S. HEALTHSTAR CORP

#636

CHECK AMOUNT

THE SUM 5000 Dollars and 00 Cents 08-29-86 $*****5,000.00

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MINNEAPOLIS, MN 55416

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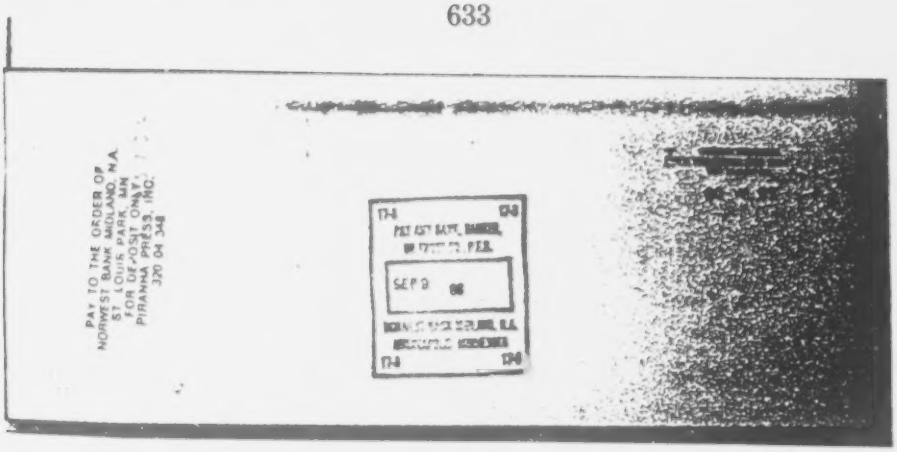
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320 04 348
SEP 9 88

U.S. HEALTH
Corporation

Eric Chapman III, J.D.
President
Chief Executive Officer

3555 Olentangy River Rd
Columbus, Ohio 43214
(614) 261-5424

September 3, 1986

Gary Diamond
President
Piranha Press
4504 Excelsior Blvd.
Minneapolis, MN 55416

Dear Gary

Enclosed you'll find the $5,000 honorarium for Dave Durenberger's October 11 speaking engagement at the U.S. Health Seminar.

We are proceeding with arrangements for his visit as outlined in your letter. The only exception is that the Senator's office said they prefer to make his travel arrangements.

Thank you.

Anne Klie

Anne Klie
Administrative Director
Corporate Development

AK/apc
Enclosure

U.S. HEALTH
Corporation

Eric Chapman III, J.D.
President
Chief Executive Officer

3555 Olentangy River Rd
Columbus, Ohio 43214
(614) 261-5424

September 18, 1986

Senator Dave Durenberger
c/o Jodi Mathison
Russell Building - Room 154
Washington, D.C. 20211

Dear Senator Durenberger

We are looking forward to having you as a speaker at the October 11 U.S. Health Seminar in Columbus, Ohio.

As you will see from the enclosed agenda, you are scheduled to speak from 8:15 a.m. - 9 a.m. at the Hyatt Regency-Columbus. Your topic is titled, "Washington Update." We'd like to hear your comments on the proposed .5 percent increase in Medicare prospective rates for fiscal 1987, pressures resulting from Gramm-Rudman legislation and other information pertinent to the hospitals in our system.

With five affiliated and two managed hospitals, U.S. Health is the largest non-profit system in Ohio. The enclosed folder is provided as an overview of the system. The audience on October 11 will be composed of U.S. Health board members, medical staff leadership and executives and their spouses.

We will be in contact with your office to confirm your travel arrangements and audiovisual needs. If I can provide additional information, please don't hesitate to contact me.

Best wishes

Anne Klie

Anne Klie
Administrative Director

AK/apc
Enclosure

M

Riverside Methodist Hospital
Columbus, Ohio

Riverside Continuum Health Services
Columbus, Ohio

RMH Foundation
Columbus, Ohio

U.S. HealthCare
Columbus, Ohio

Mercy Hospital
Portsmouth, Ohio

Scioto Memorial Hospital
Portsmouth, Ohio

Southern Hills Hospital
Portsmouth, Ohio

Hardin Memorial Hospital (managed)
Kenton, Ohio

Member—Voluntary Hospitals of America

HYATT REGENCY COLUMBUS

AT OHIO CENTER

350 NORTH HIGH STREET
COLUMBUS OHIO 43215 USA
614 463 1234

SETTLEMENT

CLERK	REG	DATE	TIME	TYPE	AMOUNT

NAME AND ADDRESS

DURENBERGER, DAVE

US HEALTH CORP
3555 OLENTANGY RIV.
COLUMBUS
OH 43214

ROOM NO	RATE	PERSONS	NIGHTS	FOLIO NO	PAGE
1714	70.00	1		335920	1

GROUP NAME

CORP

ARRIVED: OCT 10 10:30 PM

TYPE: CM/B

RESERVATIONS: ALL-KLIE, A

DEPARTMENT	CHARGE	CREDIT	BALANCE	EXPLANATION
439 ROOM	70.00			
TAX	8.05			
OCT 10 86			78.05	BALANCE
13 GLOARDEN	8.32			

DURENBERGER, DAVE
US HEALTH CORP
3555 OLENTANGY RIV.
COLUMBUS
OH 43214

16 DIRBIL		86.37		
OCT 11 86 7:51 PM	KC			CHECKOUT
CURR. BAL			0.00	OCT 11 86 SAT 09:19 PM
DIRECT BIL			86.37	
TOTAL DUE			86.37	

Z

Our Spirit Starts with a Smile

I AGREE THAT MY LIABILITY FOR THIS BILL IS NOT WAIVED AND I AGREE TO BE HELD PERSONALLY LIABLE IN THE EVENT THAT THE INDICATED PERSON, COMPANY OR ASSOCIATION FAILS TO PAY FOR ANY PART OR THE FULL AMOUNT OF THESE PURCHASES.

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939

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INVOICE

SALES PERSON: 41 ITINERARY/INVOICE NO. 0004534 DATE: 10 OCT
CUSTOMER NBR: 024444 DUPLICATE ANJEOD PAGE: 1

TO: SEN DAVID F DURENBERGER
154 RUSSELL SENATE OFF BLDG
WASHINGTON DC 20510

THANK YOU FOR FAVORING WITH YOUR TRAVEL BUSINESS. MUST PAY THE AIRLINES T... WEEK FOR ALL TICKETS ISS... WE WILL APPRECIATE RECEI... PAYMENT FOR YOUR TICK... PROMPTLY.

PLEASE REMIT FROM THIS INVOICE

FOR: DURENBERGER/DAVID F SEN

10 OCT 86 - FRIDAY						
AIR	LV WASHINGTON NATL		800P	TRANS WORLD	FLT:823	FIRST CLASS
	AR COLUMBUS	OH	909P	NON-STOP		
	RESERVED SEATS		1C			
11 OCT 86 - SATURDAY						
AIR	LV COLUMBUS	OH	1038A	AMERICAN	FLT:557	FIRST CLASS
	AR CHICAGO OHARE		1045A	NON-STOP		
	RESERVED SEATS		4E			
AIR	LV CHICAGO OHARE		1125A	AMERICAN	FLT:337	FIRST CLASS
	AR MINNEAPOLIS ST PL		1231P	NON-STOP	SNACK	
	RESERVED SEATS		4F			

AIR TICKET/S 0067858366539 FOR DURENBERGER DAVID F 610.

SUB TOTAL 610.

TOTAL AMOUNT 610.

OK
AKlee
10-20-86

CUSTOMER COPY

Welcome to The Challenge of Leadership

October 11, 1986
Hyatt Regency - Columbus

7:00 - 8:00 a.m.	Registration and Continental Breakfast Regency North Ballroom
8:00 - 8:15 a.m.	**Opening Remarks** Delaware Room
	Erie Chapman, J.D., President and Chief Executive Officer, U.S. Health Corp.
8:15 - 9:00 a.m.	**Washington Update**
	Senator Dave Durenberger (R-Minn.)
9:00 - 9:40 a.m.	**Growth and Compassion**
	Gerald Mayo, Sr., Chairman of the Board, U.S. Health Corp.
	Erie Chapman, J.D.
9:40 - 9:50 a.m.	Break
9:50 - 11:40 a.m.	**Peak Performers**
	Dr. Charles Garfield Author, "Peak Performers," President, Performance Sciences
11:40 - 12:00	Informal Session
	Dr. Charles Garfield
12:00 - 1:00 p.m.	Lunch Regency North Ballroom
1:00 - 2:00 p.m.	**Understanding Consumer Behavior: Avoiding Promotional Devastation** Delaware Room
	Dr. Roberta Clarke Professor of Marketing Boston University
2:00 - 2:15 p.m.	Break
2:15 - 3:30 p.m.	**Growth and Compassion**
	Erie Chapman, J.D.
3:30 p.m.	Reception

U.S. HEALTH
Corporation

WORLD AFFAIRS SEMINAR

University of Wisconsin-Whitewater
Whitewater, WI 53190

GENERAL MANAGER
Dr. Dale E. Brock
Ms. Dee Grover, Secy
(414) 472-1131

ACADEMIC COORDINATOR
Dr. Charles E. Cottle
Dr. Lawrence W. Newman, Asst.
(414) 472-3373

Dedicated to the advancement of international goodwill and peace through a better understanding of world problems

April 18, 1985

The Honorable David Durenberger
United States Senator
353 Russell Senate Office Building
Washington, D.C. 20510

Attention: Ms. Anne Kelly

Dear Senator Durenberger,

The purpose of this letter is to invite you to be the keynote speaker at the Ninth Annual World Affairs Seminar for High School Students which will be held on the campus of the University of Wisconsin-Whitewater during the week of June 9-14, 1985. The keynote address is scheduled for 7:45 p.m. C.D.T. on Sunday evening, June 9, 1985.

Sponsored by District #627 of Rotary International in cooperation with the University of Wisconsin-Whitewater, the World Affairs Seminar is attended by more than 750 high school seniors from over thirty states and 50 countries. To assure an international dimension to the seminar, 20% of the participants are foreign exchange students. United States participants are drawn primarily from the midwest, but some students do attend from as far away as California and Hawaii. The participants are chosen, in most cases, by selection committees in high schools and are sponsored by local Rotary Clubs and other service organizations. Generally speaking, these students are a bright group of college bound individuals who have demonstrated a real interest in foreign policy and international relations.

Previous seminars have dealt with topics such as the normalization of relations with China, SALT II, the Middle East, food, energy, South Africa, the Panama Canal, the Soviet invasion of Afghanistan, etc. Topics this year will include nuclear arms control and disarmament, Central America, the Middle East, and the politics of world hunger.

As keynote speaker you would have the freedom to choose the title of your remarks and establish the emphasis on the various topics that you prefer. Our budget permits us to pay your round-trip transportation by air from Washington to Milwaukee, and offer you an honorarium of $3000.00. We will, in addition, handle tranportation to and from Milwaukee to Whitewater (approximately 60 miles) and pay the costs of lodging.

SPECIAL
COUNSEL
HEARING
EX. 199

A

In the past the format of the keynote address has been that the speaker delivers a formal address of approximately 40 minutes duration, and then takes questions from the floor. If possible, we would like to continue with this format.

If you are willing to accept this invitation, I will be happy to make the necessary arrangements with the appropriate member of your staff. Should you have any questions about this invitation, do not hesitate to call me. I can be reached at the number on the letterhead, through the Department of Political Science at 414-472-1124, or at home, 414-473-6611.

We have been extremely fortunate in past years to attract excellent keynote speakers, including Senator Dick Clark, Senator George McGovern, Senator Gaylord Nelson, Representative Les Aspin, Paul Warnke, and Leslie Gelb. I am hopeful that you will also accept our invitation, and I look forward to hearing from you.

Sincerely yours,

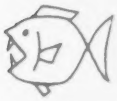
Charles E. Cottle

Charles E. Cottle
Academic Coordinator
Associate Professor

cc: Dale Brock, General Manager

B

PIRANHA



PRESS

Gary L. Diamond
Publisher

May 13, 1985

Mr. Charles E. Cottle
Academic Coordinator
University of Wisconsin--Whitewater
Whitewater, WI 53190

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Cottle:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the Ninth Annual World Affairs Seminar on June 9, 1985.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. · MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

C

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Anne Kelly at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Anne Kelly
Ms. Kitty Gamble

D

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
June 9, 1985	7:45 p.m.	Whitewater	$4,000

E

WORLD AFFAIRS SEMINAR

University of Wisconsin-Whitewater
Whitewater, WI 53190

GENERAL MANAGER
Dr. Dale E. Brock
Ms. Dee Grover, Secy
(414) 472-1131

ACADEMIC COORDINATOR
Dr. Charles E. Cottle
Dr. Lawrence W. Newman, Asst
(414) 472-3373

Dedicated to the advancement of international goodwill and peace through a better understanding of world problems

May 30, 1985

COPY

Mr. Gary Diamond, President
Piranha Press
4504 Excelsior Blvd.
Minneapolis, MN 55416

Dear Mr. Diamond:

Enclosed is a check in the amount of $4,000 for advance payment of Senator Dave Durenberger's Keynote Speaking engagement before the Ninth Annual World Affairs Seminar at 7:45 P.M. on June 9, 1985, as arranged by Dr. Charles Cottle, Academic Coordinator for the Seminar.

If Senator Durenberger is unable to fulfill this commitment, we would expect a refund of the full amount of $4,000.

Very truly yours,

Dale E. Brock

Dale E. Brock
General Manager

DEB/df
Encl.

cc Dr. Cottle

F

WISCONSIN WORLD AFFAIRS COUNCIL, INC.
519 W. STARIN RD.
WHITEWATER, WI 53190

513

May 30 19 85 79-800/759

PAY TO THE ORDER OF Piranha Press $ 4,000 00

Four Thousand and 00/100 DOLLARS

COMMERCIAL Bank
WHITEWATER, WISCONSIN 53190

PRESIDENT AND ASSISTANT TREASURER

Dale E. Brock

June 9, 1985

FOR Keynote Speaker - Sen Dave Durenberger

⑈000513⑈ ⑆075908006⑆ ⑈20 73 3⑈ ⑈00004000000⑈

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WORLD AFFAIRS SEMINAR

University of Wisconsin-Whitewater
Whitewater, Wis. 53190

GENERAL MANAGER
Dr. Dale E. Brock
(414) 472-1131

ACADEMIC COORDINATOR
Dr. Charles E. Cottle
(414) 472-1124

Dedicated to the advancement of international goodwill and peace through a better understanding of world problems

May 31, 1985

Ms. Anne Kelly
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Kelly,

Please find enclosed the airline ticket for Senator Durenberger's flight to Milwaukee, Wisconsin on Sunday, June 9, 1985. He will be met at the airport by a member of the Whitewater Rotary Club who will be carrying a World Affairs Seminar placard for identification. The trip from Milwaukee to Whitewater should take approximately one hour.

Thank you for your attention.

Sincerely yours,

Charles E. Cottle

Charles E. Cottle
Academic Coordinator
Associate Professor

cc: Dr. Dale Brock

I

NINTH ANNUAL WORLD AFFAIRS SEMINAR

UNIVERSITY OF WISCONSIN-WHITEWATER

June 9-14, 1985

PROGRAM

SUNDAY, June 9

12:30 - 6:30 p.m.	Check-in - Wells Hall Main Lounge
5:00 - 6:30 p.m.	Evening Meal - Esker Dining Hall
7:00 - 9:00 p.m.	Opening Session - Hyer Hall Auditorium Welcome and Orientation
	Keynote Address: The Honorable David Durenberger, U.S. Senator, Minnesota
9:00 - 10:45 p.m.	Get Acquainted Mixer - University Center Warhawk Room
11:00 p.m.	Curfew - Dorm Doors Locked
11:50 p.m.	Lights Out - Quiet

MONDAY, June 10

NUCLEAR ARMS CONTROL AND DISARMAMENT

7:00 - 8:00 a.m.	Breakfast - Esker Hall
8:30 - 9:45 a.m.	First General Session - Hyer Hall Auditorium
	"A History of the Strategic Arms Race," Mr. Thomas Longstreth, Arms Control Association.
9:45 - 10:05 a.m.	Break
10:05 - 11:20 a.m.	"Nuclear War and the Future of Civilization," Professor Dick Ringler, Department of Scandinavian Studies, University of Wisconsin-Madison.
11:20 - 1:00 p.m.	Lunch Break - (Lunch in Esker Hall - 11:45 - 12:45)
1:00 - 2:00 p.m.	Second General Session - Hyer Hall Auditorium
	"The Current Status of Arms Control Negotiations under the Reagan Administration," Mr. Bernard Francis Halloran, Special Assistant to the Director, U.S. Arms Control and Disarmament Agency.
2:00 - 2:05 p.m.	Stand-up pause

2:05 - 3:05 p.m.	"Nuclear Sense and Nuclear Nonsense," Dr. George Stanford, Argonne National Laboratory.
3:05 - 3:20 p.m.	Break
3:20 - 4:15 p.m.	Discussion Groups - Heide Hall - See Index
4:45 - 5:45 p.m.	Evening Meal - Esker Hall
6:00 - 11:00 p.m.	Choice of Recreational Activities - See List
6:15 - 10:45 p.m.	Educational Films - Wells Hall - See Schedule
11:00 p.m.	Curfew - Dorm Doors Locked
11:50 p.m.	Lights Out - Quiet

TUESDAY, June 11

THE CRISIS IN THE MIDDLE EAST

7:00 - 8:00 a.m.	Breakfast - Esker Hall
8:30 - 9:45 a.m.	Third General Session - (Split Session) Hyer Hall Auditorium - For students whose last name begin with letter "A" - "K" "A History of the Arab-Israeli Dispute," Professor Mark Tessler, Department of Political Science, University of Wisconsin-Milwaukee. Center of the Arts Auditorium - For students whose last name begin with letter "L" - "Z" "The People and Politics of the Middle East," Professor Stephen Humphreys, Department of History, University of Wisconsin-Madison.
9:45 - 10:05 a.m.	Break
10:05 - 11:20 a.m.	Hyer Hall Auditorium - For students whose last name begin with letter "L" - "Z" "A History of the Arab-Israeli Dispute," Professor Mark Tessler, Department of Policial Science, University of Wisconsin-Milwaukee. Center of the Arts Auditorium - For students whose last name begin with letter "A" - "K" "The People and Politics of the Middle East," Professor Stephen Humphreys, Department of History, University of Wisconsin-Madison.

11:20 - 1:00 p.m. Lunch Break - (Lunch in Esker Hall 11:45 - 12:45)

1:00 - 2:15 p.m. Fourth General Session - Hyer Hall Auditorium

"The U.S. Role and Objectives in the Middle East,"
U.S. Department of State.

2:15 - 2:35 p.m. Break

2:35 - 3:35 p.m. Discussion Groups - Heide Hall - See Index

4:45 - 5:45 p.m. Evening Meal - Esker Hall

6:00 - 11:00 p.m. Choice of Recreational Activities - See List

6:15 - 10:50 p.m. Educational Films - Wells Hall - See Schedule

11:00 p.m. Curfew - Dorm Doors Locked

11:50 p.m. Lights Out - Quiet

WEDNESDAY, June 12

U.S. FOREIGN POLICY AND THE FUTURE OF CENTRAL AMERICA

7:00 - 8:00 a.m. Breakfast - Esker Hall

8:30 - 9:45 a.m. Fifth General Session - (Split Session)

Hyer Hall Auditorium - Students whose badge number ends in an odd number - 1-3-5-7-9-

"The People and Politics of Central America,"
Ms. Anne Nelson, Canadian Broadcasting System.

Center of the Arts Auditorium - Students whose badge number ends in an even number - 2-4-6-8-0-

"U.S. Foreign Policy toward Central America,"
Mr. John Curry, Bureau of Inter-American Affairs,
U.S. Department of State.

9:45 - 10:05 a.m. Break

10:05 - 11:20 a.m. Hyer Hall Auditorium - Students whose badge number ends in an even number - 2-4-6-8-0-

"The People and Politics of Central America,"
Ms. Anne Nelson, Canadian Broadcasting System.

Center of the Arts Auditorium - Students whose badge number ends in an odd number - 1-3-5-7-9-

"U.S. Foreign Policy toward Central America,"
Mr. John Curry, Bureau of Inter-American Affairs,
U.S. Department of State.

11:20 - 1:00 p.m.	Lunch Break - (Lunch in Esker Hall 11:45 - 12:45)
1:00 - 3:00 p.m.	Sixth General Session - Hyer Hall Auditorium
	Panel Discussion on Central American Issues
	Participants:
	Professor Daniel DiPiazza, Department of Political Science, University of Wisconsin-Whitewater.
	Professor Charles Weston, Department of Political Science, Western Illinois University.
	Mr. John Curry, Cureau of Inter-American Affairs, U.S. Department of State.
	Mr. George Black, Editor, "Report on the Americas," North American Congress on Latin America.
3:00 - 3:20 p.m.	Break
3:20 - 4:15 p.m.	Discussion Groups - Heide Hall - See Index
5:00 - 7:00 p.m.	Picnic - Field Area between Book Store & Tennis Courts
7:00 - 11:00 p.m.	Choice of Recreational Activities - See List
6:15 - 10:50 p.m.	Educational Films - Wells Hall - See Schedule
11:00 p.m.	Curfew - Doorm Doors Locked
11:50 p.m.	Lights Out - Quiet

THURSDAY, June 13

WORLD HUNGER AND INTERNATIONAL POLITICS

7:00 - 8:00 a.m.	Breakfast - Esker Hall
8:30 - 9:45 a.m.	Seventh General Session - Hyer Hall Auditorium
	"An Analysis of the Causes of World Hunger." Professor John Patterson and Professor Charles Varney, Department of Geography, University of Wisconsin-Whitewater.
9:45 - 10:05 a.m.	Break
10:05 - 11:20 a.m.	"An Analysis of the Causes of World Hunger," cont'd, Professor John Patterson and Professor Charles Varney, Department of Geography, University of Wisconsin-Whitewater.
11:20 - 1:00 p.m.	Lunch Break - (Lunch in Esker Hall 11:45 - 12:45)

5

1:00 - 2:15 p.m. Eighth General Session - Hyer Hall Auditorium

"The Role of the United Nations in the Struggle Against World Hunger," Mr. Jay Levy, Information Officer, Food and Agriculture Organization of the United Nations, Liaison Office for North America.

2:15 - 2:35 p.m. Break

2:35 - 3:35 p.m. Discussion Groups - Heide Hall - See Index

5:00 - 6:30 p.m. International Student Exhibits - Wells Hall

7:00 - 8:45 p.m. Banquet in Esker Hall

8:45 - 11:45 p.m. Dance in Warhawk Room of University Center

12:30 a.m. Curfew - Dorm Doors Locked

12:50 a.m. Lights Out - Quiet

FRIDAY, June 14

(CLOSING SESSION)

7:00 - 8:00 a.m. Breakfast - Drumlin Hall

8:30 - 9:45 a.m. Ninth General Session - Hyer Hall Auditorium

International Student Panel

9:45 - 9:50 a.m. Stand-up Pause

9:50 - 11:00 a.m. Open Forum: Discussion by all participants

11:00 - 11:20 a.m. Closing remarks by Charles E. Cottle, Associate Professor of Political Science, University of Wisconsin-Whitewater.

11:30 - 12:45 a.m. Lunch - Esker Hall

11:30 - 2:00 p.m. Students Check-out of Dorm Rooms

N

INDEX FOR DISCUSSION GROUPS

Group Number	Heide Hall Room Number	Group Number	Heide Hall Room Number
1	102	15	216
2	112	16	217
3	114N	17	218
4	114S	18	219
5	115N	19	301
6	115S	20	303
7	201	21	309
8	202	22	310
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10	204	24	312
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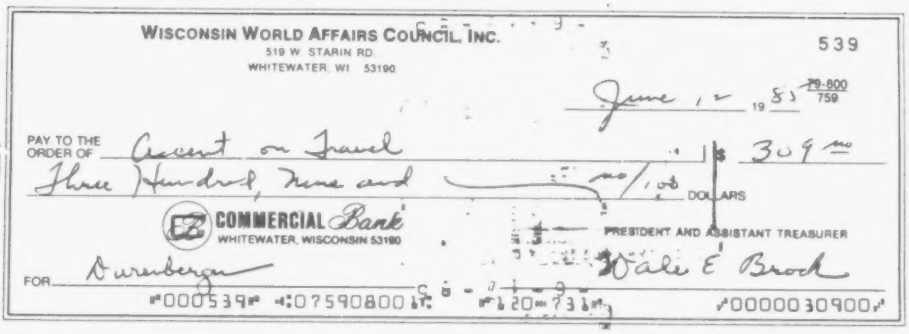
12	213	26	314
13	214	27	315
14	215	28	316



WISCONSIN WORLD AFFAIRS COUNCIL, INC.
519 W. STARIN RD.
WHITEWATER, WI 53190

539

June 1st 19 83 79-800/759

PAY TO THE ORDER OF Accent on Travel $ 309.00

Three Hundred, Nine and no/100 DOLLARS

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WHITEWATER, WISCONSIN 53190

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Dale E Brock

FOR Darenberger

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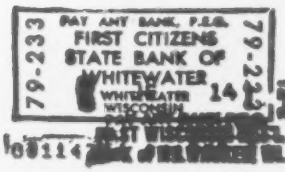
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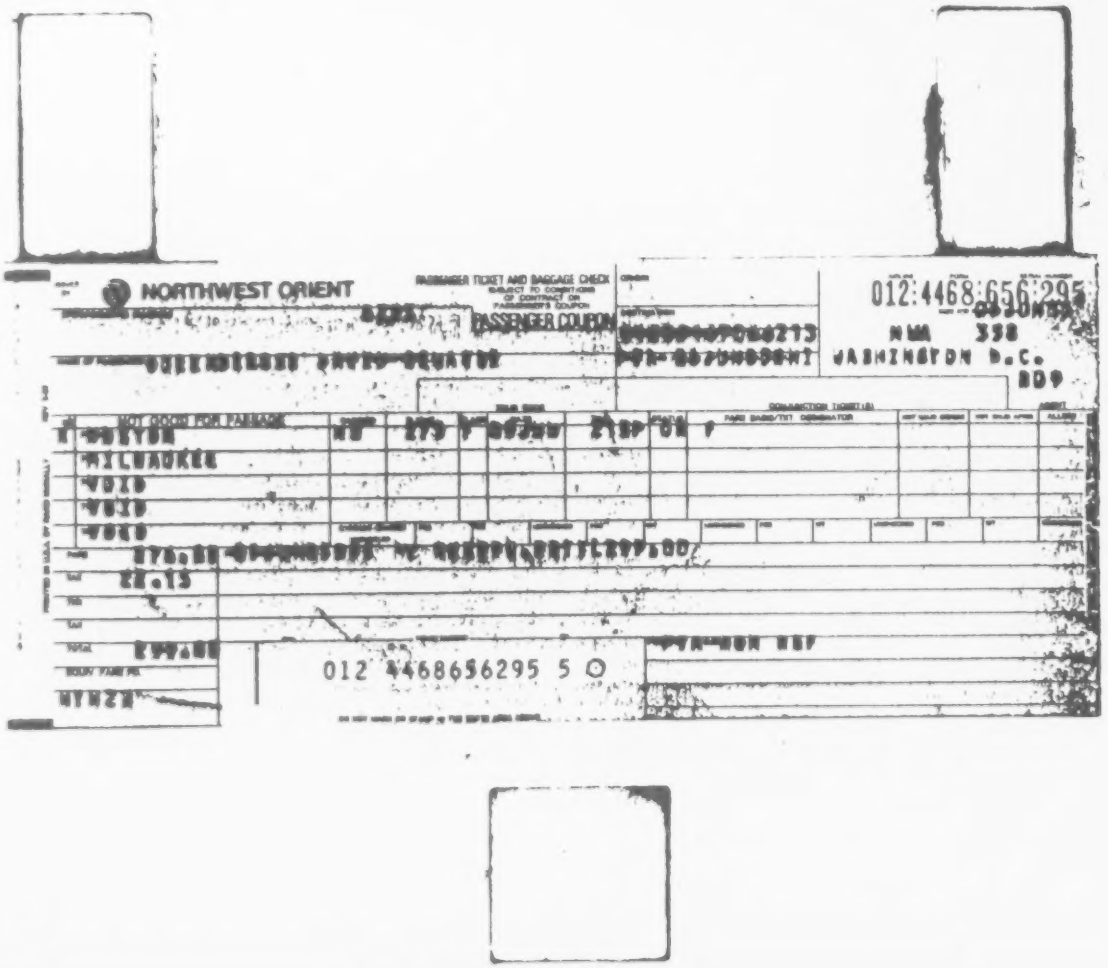
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Washington DC 20006
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Corporate Director
Government Relations

WARNER LAMBERT

July 15, 1986

Ms. Jodi Mathison
Appointments Secretary to
U.S. Senator David Durenberger
SR-154 Russell Senate Office
Building
Washington, DC 20510

Re: July 21, 1986 Visit to Warner-Lambert

Dear Jodi;

We are delighted to confirm that Dave will be joining us at Morris Plains next Monday afternoon. Enclosed please find a copy of our schedule as well as a brief background paper that I have prepared for his information.

Please let me know if there is any further information you need.

Thanks very much for your help.

With best wishes,

Brad

W. Bradford Gary

cc: Chip Kahn
Kaye Weinstock

SPECIAL
COUNSEL
HEARING
EX. 200

A

July 15, 1986
CONFIDENTIAL

To: Senator Durenberger

From: Washington Office/Warner-Lambert

Re: BACKGROUND PAPER - WARNER-LAMBERT COMPANY

The Warner-Lambert Company is a major health care and consumer products company with over $3.2 billion in world wide sales. The company has 33,000 employees in over 100 production centers and eight research labs.

POLITICAL HISTORY & SENIOR OFFICERS

The company established a political action committee "WALPAC" in 1986. Currently over 46% of PAC "eligible" employees are members of WALPAC.

Warner-Lambert (WL) established a Washington D.C. office in April 1986 and appointed W. BRADFORD GARY as corporate director in charge of Washington operations. Mr. Gary previously served as head of the Washington office of Baxter Travenol and prior to that represented 3M Company/Health Care before the Congress.

Although the company's direct Washington involvement intensified in 1986, senior executives of the company have long been active in federal affairs.

The company's founder - ELMER BOBST - was a close personal friend of Richard Nixon. During Nixon's "exile" from politics (pre-presidential) Bobst secured a partnership for Nixon with a major New York law firm. A young Senator from Massachusetts learned "speed reading" with WL employees at a course offered by Evelyn Wood at the Bromo-Seltzer/Warner-Lambert offices in Baltimore, Maryland. JOHN F. KENNEDY traveled to Baltimore to join his friends, LEMOYNE (LEM) BILLINGS and FRANK MARKOE (former WL Vice Chairman), for the evening sessions.

The company's current chairman and CEO, JOSEPH (JOE) D. WILLIAMS is chairman of the International Pharmaceutical Manufacturers Association (IFPMA). He also served as chairman of the U.S. Pharmaceutical Manufacturers Association (PMA) during the passage of the Patent-Term Restoration Act.

Mr. Williams serves on the Board of Directors of Project Hope, the United Negro College Fund, Columbia University, American Telephone and Telegraph (AT&T), J.C. Penney, as well as chairing the Committee for the Establishment of the New Jersey Science Center at Rutgers University.

MR. RONALD E. ZIER is chairman of WALPAC, the Warner-Lambert Political Action Committee and is Vice President of Public Affairs for the Corporation. Mr. Zier also serves as Mr. Williams' executive officer and supervises the firm's Washington D.C. office.

WARNER-LAMBERT MAJOR FEDERAL ISSUES

1.) **Increased FDA Funding**

WL supports increased congressional appropriations for the U.S. Food and Drug Amdinistration (FDA) in order to expedite the processing of new drug applications (NDA's). Many new drug molecules receive faster clearance overseas, disadvantaging American patients.

2.) **Puerto Rico Tax Credits**

WL supports continuation of the U.S. tax incentive program in the Commonwealth of Puerto Rico. Warner-Lambert is the second largest pharmaceutical firm in number of employees (1,400) on the island. Facilities are located at Vega Baja, Carolina and the Port of Fajardo. Fully 40% of the firm's U.S. production will be sourced from the Commonwealth by 1987.

3.) **Restricted Marketing of OTC/RX Capsules**

Warner-Lambert is the largest manufacturer of empty gelatin capsules for use in the pharmaceutical industry.

The company feels strongly that U.S. consumers should continue to have direct access to properly sealed and tamper resistant OTC ("over-the-counter") drug products. The company believes that the availability of cyanide must be severely curtailed. Criminal penalties should be increased for criminal tampering of food and drug products.

C

WL COMPANY PRODUCTS

The company has three major product groups. The following is representative of the product lines:

1.) RX Pharmaceutical
(Through Parke Davis Group)
Dilantin (anti-epileptic)
Vira-A (treatment of herpes)
Lopid (cholesterol inhibitor)
Loestrin (birth control)
Procan SR (anti-arythmia)

2.) OTC Pharmaceuticals

Rolaids (anti-acid)
Listerine (antiseptic)
Myadec (vitamins)
Benadryl (antihistamine)
Sinutab (sinus)
Theracal (calcium supplement)

3.) Mints, Gums and Other

Certs
Dentyne
Trident
Chiclets
Clorets

Schick Razors
Tetra Aquarium Products

WARNER LAMBERT

SEE BACK FOR INSTRUCTIONS

CHECK REQUEST

Division: CORPORATE | Department: PUBLIC AFFAIRS | Request Date: 7/14/86

Make Check Payable To: PIRAHNA PRESS Fed. ID #41-088-115

Street Address: 4504 EXCELSIOR BOULEVARD (DO NOT MAIL)

City: MINNEAPOLIS | State: MINN. | Zip: 55416

Reason for Disbursement: Speaking honorarium for Senator David F. Durenberger

Special Check Stub Description (30 Character Limit):

Account(s) to be Charged:

DIV	BR	RESP	ACCT	SUB	ANALYSIS	AMOUNT
						$ 1,000.00

Total Amount of Check: $ 1,000.00

Originated By	Approved by (1st Level) (Name Printed)	Approved By (2nd Level) (Name Printed)
Ext # 6859 K. C. Matejcek	Ext # 2731 R. E. Zier	Ext # 2648 A. R. Rizzo
Signature: Kare Matejcek	Signature:	Signature:

Under normal conditions, a check will be mailed directly to the payee in approximately five working days after this document is received by Accounts Payable. If you require an earlier payment date, or if you have attached the Special Instructions Card, please indicate.

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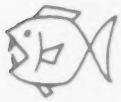

PRESS

Gary L. Diamond
Publisher

July 18, 1986

Mr. W. B. Gary
Corporate Director
Warner-Lambert
1667 K Street NW
Suite 1270
Washington, DC 20006

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Mr. Gary:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before the employees of Warner Lambert on July 21, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

G

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

cc: Ms. Jodi Mathison
Ms. Kitty Gamble

APPEARANCE SCHEDULE

Date	Place	Amount
July 21, 1986	New Jersey	$2,000

SCHEDULE FOR UNITED STATES SENATOR

DAVID DURENBERGER
Chairman, Subcommittee on Health

(Current as of 15 July 1986)

Visit to Warner-Lambert Company, Morris Plains, NJ

July 21, 1986

10:30 am	Company Jet departs Morristown, NJ.
11:30 am	Land at Boston/Logan, Carey Limousine to meet.
2:00 pm	W. Bradford Gary meets Senator Durenberger at Algonquin Club, 217 Commonwealth Ave. Boston, MA., 02116. (617-266-2400) Depart for airport.
2:30 pm	Company jet departs Boston for Morristown, NJ airport.
3:20 pm (approx.)	Arrive Morristown Airport. WL helicopter departs for WL/Tabor Road complex.
3:40 pm (approx.)	Arrive WL
4:00 pm	Senator Durenberger presentation: "Future of Health Care" WL cafeteria
5:00 pm	Coffee with WL officers & WALPAC (Company Political Action Committee) Trustees in Board Room.
5:30 pm	Depart WL/Tabor Road Complex via helicopter to Newark International Airport (EWR).
6:30 pm	Senator departs Newark for WDC via Piedmont 253.

call Brad re → change

- Prepared by the Washington Office - Warner-Lambert Company. (202-862-3840)

SPECIAL INSTRUCTIONS CARD for check to be issued per attached,

WARNER LAMBERT

☒ Check Request ☐ Vendor Invoice

Payee: PIRANHA PRESS Amount $ 2,000.00

Prepared By: L. Heissenbuttel Date: 7/23/86 Ext.: 3373

☐ Enclosure(s) or Attachment(s) to be mailed with check – number of pages ____

☐ Other Special Handling (explanation required)

☒ Do not mail check directly to payee (explanation, authorized signature and "return to" information required)

Explanation: Return to K. C. Matejcek for transmittal

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Dept.: Public Affairs Bldg.: 56-1

Division Controller/VP Finance Authorization:

For Accounting Use Only

Date Received	Check Date	Check Number	Check Amount	Date Mailed

A10BWL

From
the
Desk
of R. J. DIRCKS

7/23/86

Mr. A. R. Rizzo

Karen Matejcek advised late yesterday that Sen. Durenberger was closing his books this Friday July 25. Our check in the amount of $2,000 must be received by him no later than 7/25.

Karen requests that we put a "RUSH" on this so that it gets back to her late today. She will then express it out to Sen. Durenberger.

Thank you for your assistance in this matter.

J. Jacek

jj
att.

L

Voucher # 57906

Vendor # P.O.B.56.0.65. Short Name P.L.Bamlin P.S.C

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Invoice # 0 Date 7/23/86

Gross Amount 3,000.00 Pack Code

CHECK # 687367 CHECK DATE 7/23/86

Account Distribution

7/25 KD

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"LAMBERT

SEE BACK FOR INSTRUCTIONS

CHECK REQU

Division: CORPORATE

Department: PUBLIC AFFAIRS

Request Date: 7/23/86

Make Check Payable To: PIRANHA PRESS Fed. ID #41-088-115

Street Address: 4504 EXCELSIOR AVENUE (DO NOT MAIL)

City: MINNEAPOLIS

State: MN

Zip: 55416

Reason for Disbursement: Speaking honorarium for Senator David F. Durenberger

Special Check Stub Description (30 Character Limit):

Account(s) to be Charged:

DIV	DEPT	REGION	ACCT	SUBS	ANALYSIS	$ AMOUNT
						2 0 0 0 0 0

Total Amount of Check: $ 2,000

Originated By: Ext # 6859 K. C. Matejcek

Signature: Kevin Matejcek

Approved by (1st Level) (Name Printed): Ext # 2731 R. E.

Signature:

Approved By (2nd Level) (Name Printed): Ext # 2675 R. Rizzo

Signature:

Under normal conditions, a check will be mailed directly to the payee in approximately five working days after this document is received by Accounts Payable. If you require an earlier payment date, or if you have attached the Special Instructions Card, please indicate:

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WARNER LAMBERT

Warner-Lambert Company
201 Tabor Road
Morris Plains, NJ 07950

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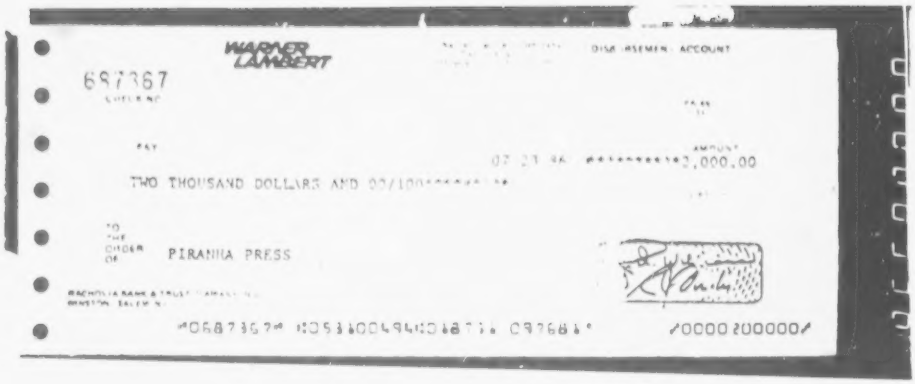
NON-NEGOTIABLE

WACHOVIA BANK & TRUST COMPANY, N.A.
WINSTON - SALEM, N.C.

⑈068736⑦⑈ ⑆053100494⑆018731 097681⑈


WARNER LAMBERT

697367

PAY

07 23 86 **********2,000.00

TWO THOUSAND DOLLARS AND 00/100**********

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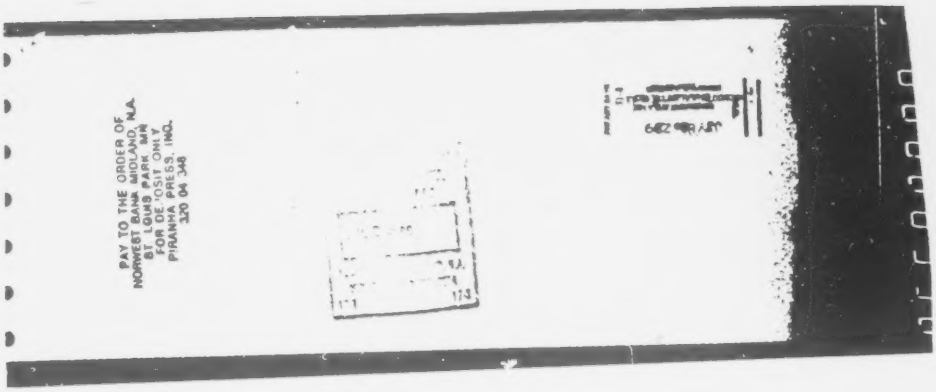
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Vendor # A0011560165 Short Name P.L.BARHA,P.A.C.

Type 1 Action 2

Invoice # VOID CHECK Date 7-31-86

Gross Amount 1,000.00 Bank Code

CHECK # 750547 CHECK DATE 7-16-86

Account Distribution

Line	Account	Div	Pr.	Resp.	Acct.	Sub	Analysis	TAX	USE TAX
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Warner-Lambert Company
1667 K Street, N.W. Suite 1270
Washington, DC 20006
202 862-3840

W. Bradford Gary
Corporate Director
Government Relations

WARNER LAMBERT

September 24, 1986

The Honorable David Durenberger
7732 Canal Court
McLean, Virginia 22102

Dear Dave:

Enclosed is a check from WALPAC - the voluntary political action committee of the employees of Warner-Lambert Company to your campaign committee.

Thanks again for visiting with us in July and endorsing the establishment of WALPAC. As you can see, we are off to a good start!

With best regards,

Brad

W. Bradford Gary

enclosure: WALPAC check #108

S

108 ✓

9/19 19 86

TO Durenberger Volunteer Committee

DEPOSITS 1000. 00

FOR

TOTAL	
THIS CHECK	
BALANCE	

WALPAC
A Political Action Committee of the Employees of Warner-Lambert Company

201 TABOR ROAD
MORRIS PLAINS, NJ 07950

108

233 22 11-05-86 210423430

Sept. 19 1986 8-7891/2720

PAY TO THE ORDER OF Durenberger Volunteer Committee $ 1,000.00

One thousand and 00/100---------- DOLLARS

PARDA FEDERAL CREDIT UNION
201 TABOR ROAD
MORRIS PLAINS, NJ 07950

ROBERT J. DRICKS, TREASURER

RONALD E. ZIER, ASST. TREASURER

FOR

⑆272078912⑆ 7111653998116⑈ 0108 ⑈0000100000⑈

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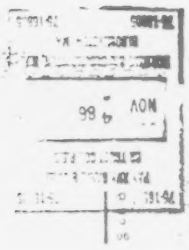

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SENATE 88
ACCT. NO 97-16-275

[redacted]

[redacted]

VENDOR NUMBER	VENDOR NAME	INVOICE NUMBER	INVOICE DATE	VOUCHR NUMBER	DUE DATE	P Y	BA NK	TY PE	CHECK NUMBER	AMOUNTS GROSS	DISCOUNT	OPEN	PAID
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A00156065	PIRANHA	0	07/14/86	D54753	07/16/86	I	MA	3	750547	1,000.00			1,000.00
A00156065	PIRANHA	0	07/23/86	D54906	07/23/86	N	MA	4	687367	2,000.00			2,000.00
VEND NAME. PIRANHA										2,000.00			2,000.00

Σ

5/2/86 SCHEDULING INFORMATION [redacted] DD wrote personal thank you to Brad Sitton

4/29/86 Event Date — Date of Request

Group Name Washington Subdivision Group

Address

Contact Barbara Stephenson Phone #'s 202-296-7116

Key People Brad Sitton - Ann Lotter Shippers LOCATION Capitol Hill Club (= Hart Club)

Place [illegible] A/2 block

Room between P & Q on Votta Pl

Phone # 333-9330

Directions

Group Size 20 lobbyists

Topic: Open topic - discussion forum Q+A

~~Honorarium~~ Piranha $2K (amount)

Expenses

ATTENDEES

See briefing book

Mike Bromberg
Boggs
Black
Timmons
Berg
JD Williams

LISTS

Membership List

Received?

Computer?

REMARKS: times fairly flexible
7-7:30 drinks Garden Cafe
~~7:30~~ 8:00 dinner to begin WPSTBU
8:30 DD would begin discussion

Call Tamara re: letter

They realize Senate schedule; DD could be late for votes
4-18-86 confirmed

SPECIAL COUNSEL HEARING EX. 201

trip
4/23
trip 4/24
Air time
rent
3 weeks Caroline Fitzsimmons
296-7116

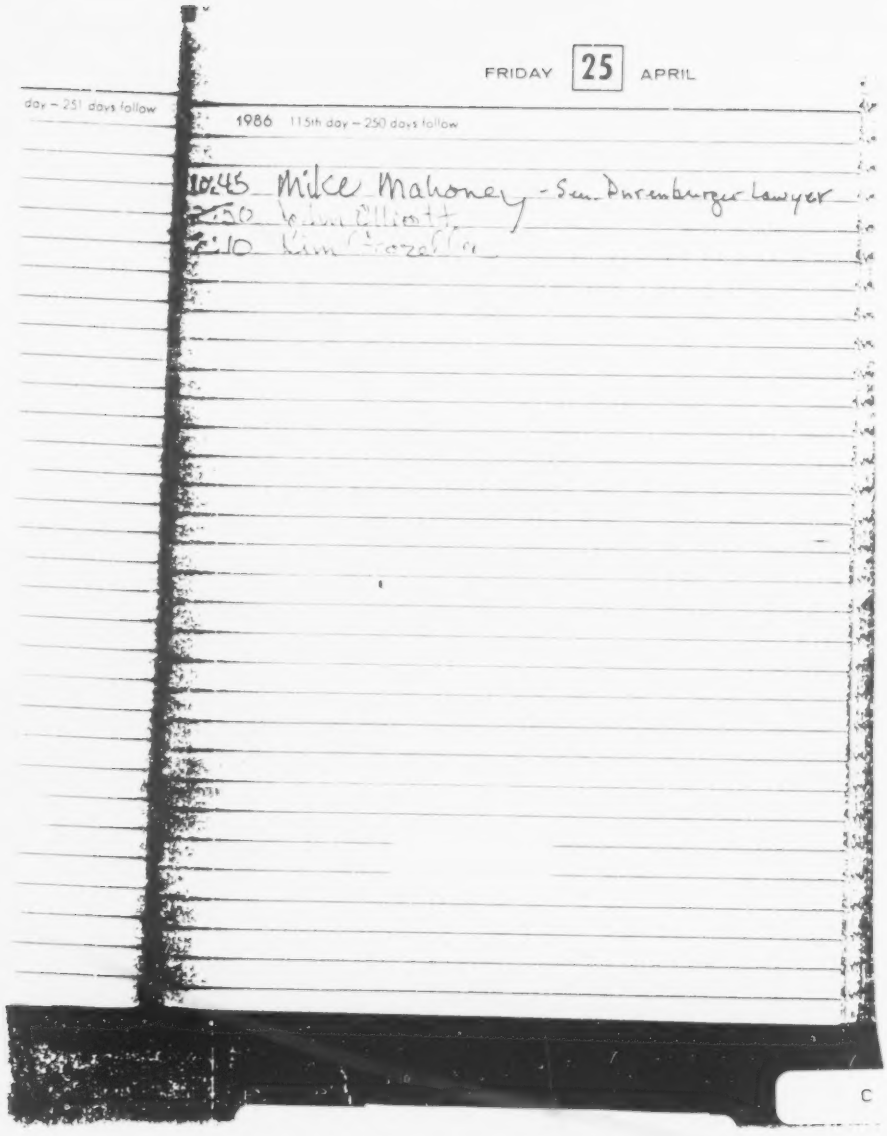
Neal Giller Haik will be out of town- trip 4/29
Am Cotton Shippers

$2K Washington Discussion Group
20 lobbyists who get together 1 a month:
have Senator speak
open topic: Q & A Discussion forum

Please or Georgetown

7-7:30 Drinks 3:30 DC would begin
7:30-7:45 Dinner

B



FRIDAY 25 APRIL

day – 251 days follow

1986 115th day – 250 days follow

10.45 Mike Mahoney - Sen. Durenberger lawyer

11.50 John Elliott

2.10 Kim Crozier

Vodi Send thanks. make p Xmas Cards all thank q mgs. D.

American Cotton Shippers Association

MAIN OFFICE: Earle N. Bolinger, Executive Vice President
Mezzanine Suite 2, Cotton Exchange Building • P.O. Box 1350 • Memphis, TN 38173
Tel: (901) 525-2272 • CABLE: AMERICASSN • TELEX 53-952

WASHINGTON OFFICE: Neal P. Gillen, Vice President & General Counsel
1725 K Street, N.W., Suite 1210 • Washington, D.C. 20006
Tel: (202) 296-7116 •

May 1, 1986

The Honorable Dave Durenberger
375 Russell Building
Washington, D.C. 20510

Dear Dave:

The members of the Washington Discussion Group are looking forward to being with you Thursday, May 8th. Attached for your information is a copy of the membership roster.

The meeting will be held at the George Town Club with cocktails served at 7:00, dinner at 8:00 with discussion to commence at the conclusion of dinner. You are expected to make some remarks to be followed by questions and answers. We usually adjourn at 10:00 PM.

If you need transportation have your office contact me.

Sincerely,

Neal P. Gillen
Vice President &
General Counsel

D

WASHINGTON DISCUSSION GROUP
MINUTES

May 8, 1986

On Thursday, May 8, the Washington Discussion Group held a business meeting at the George Town Club in Washington, D.C. Members in attendance were:

Robert W. Barrie	Philip F. Jehle
Thomas H. Boggs, Jr.	Tom Korologos
Michael D. Bromberg	Clarence Martin
Dean Burch	Michael Monroney
Richard Cook	Thomas Quinn
Richard C. Darling	William E. Timmons
Neal P. Gillen	R. Duffy Wall
Horace D. Godfrey	J. D. Williams

The dinner was hosted by Neal P. Gillen and the guest lecturer was the Honorable David F. Durenberger, a United States Senator from the State of Minnesota. Senator Durenberger was born, raised and educated in Minnesota, receiving a B.A. from St. John's University and a J.D. from the University of Minnesota Law School. Following military service as an officer with U.S. Army Intelligence, he practiced law and served as a staff assistant to the Governor. He was active in various Republican Party and Civic endeavors. In 1978 he was elected to complete the unexpired term of Hubert H. Humphrey and re-elected in 1982. In the U.S. Senate he is Chairman of the Select Committee on Intelligence, and serves on the Committees on Environment & Public Works, Finance, and Governmental Affairs.

In his prepared remarks he discussed the Tax Reform Bill. In response to questions he opined on the 1988 Elections; Generational Equity; Farm Crisis; Superfund; Intelligence Oversight; PACs; Lobbying; Pension Benefits/Individual Retirement Accounts; Health Care; Senate Leadership; and Municipal Bonds.

At the conclusion of the meeting there was no business session.

The next meeting will be held on Tuesday, May 13th, hosted by member Thomas H. Boggs, Jr., and the guest lecturer will be the Honorable Spark M. Matsunaga(D-HI).

E

WASHINGTON DISCUSSTION GROUP
MEMBERSHIP LIST

Robert W. Barrie 637-4471
General Electric Company
1331 Penn. Ave., N.W., #800
Washington, D.C. 20004

Thomas H. Boggs, Jr. 457-6000
Patton, Boggs & Blow
2550 M St., N.W.
Washington, D.C. 20037

Michael D. Bromberg 833-3090
Federation of Am. Health Systems
1111 19th St., N.W., #402
Washington, D.C. 20036

William J. Colley 457-6000
Patton, Boggs & Blow
2550 M St., N.W.
Washington, D.C. 20037

Richard Cook 955-3350
Lockhead Aircraft Corp.
1825 Eye St., N.W., #1100
Washington, D.C. 20006

Allan D. Cors 347-2270
Corning Glass Works
1455 Penn. Ave., N.W., #500
Washington, D.C. 20004

Richard C. Darling 862-4813
J.C. Penney Company
1156 15th St., N.W.
Washington, D.C. 20005

Dean Burch/ William Geoghegan 331-8566
Pierson, Ball & Dowd
1200 18th St., N.W.
Washington, D.C. 20036

Neal P. Gillen 296-7116
Am. Cotton Shippers Assn.
1725 K St., N.W., #1210
Washington, D.C. 20006

Horace D. Godfrey 785-4070
Godfrey and Associates
918 16th St., N.W.
Washington, D.C. 20006

Tom Korologos 331-1760
Timmons & Company, Inc.
1850 K St., N.W., #850
Washington, D.C. 20006

Clarence Martin 329-1538
6014 Fort Hunt
Alexandria, VA 22307

Michael Monroney 276-5010
TRW, Inc.
1000 Wilson Blvd.
Arlington, VA 22209

Thomas Quinn 887-1433
O'Connor & Hannan
1919 Penn. Ave., N.W.
Washington, D.C. 20006

William E. Timmons 331-1760
Timmons & Company, Inc.
1850 K St., N.W. #850
Washington, D.C. 20006

R. Duffy Wall 737-0100
R. Duffy Wall & Asso. Inc.
1317 F St., N.W., #400
Washington, D.C. 20004

J.D. Williams 659-8201
Williams & Jensen
1101 Conn. Ave., N.W., #500
Washington, D.C. 20036

EMERITUS MEMBERS

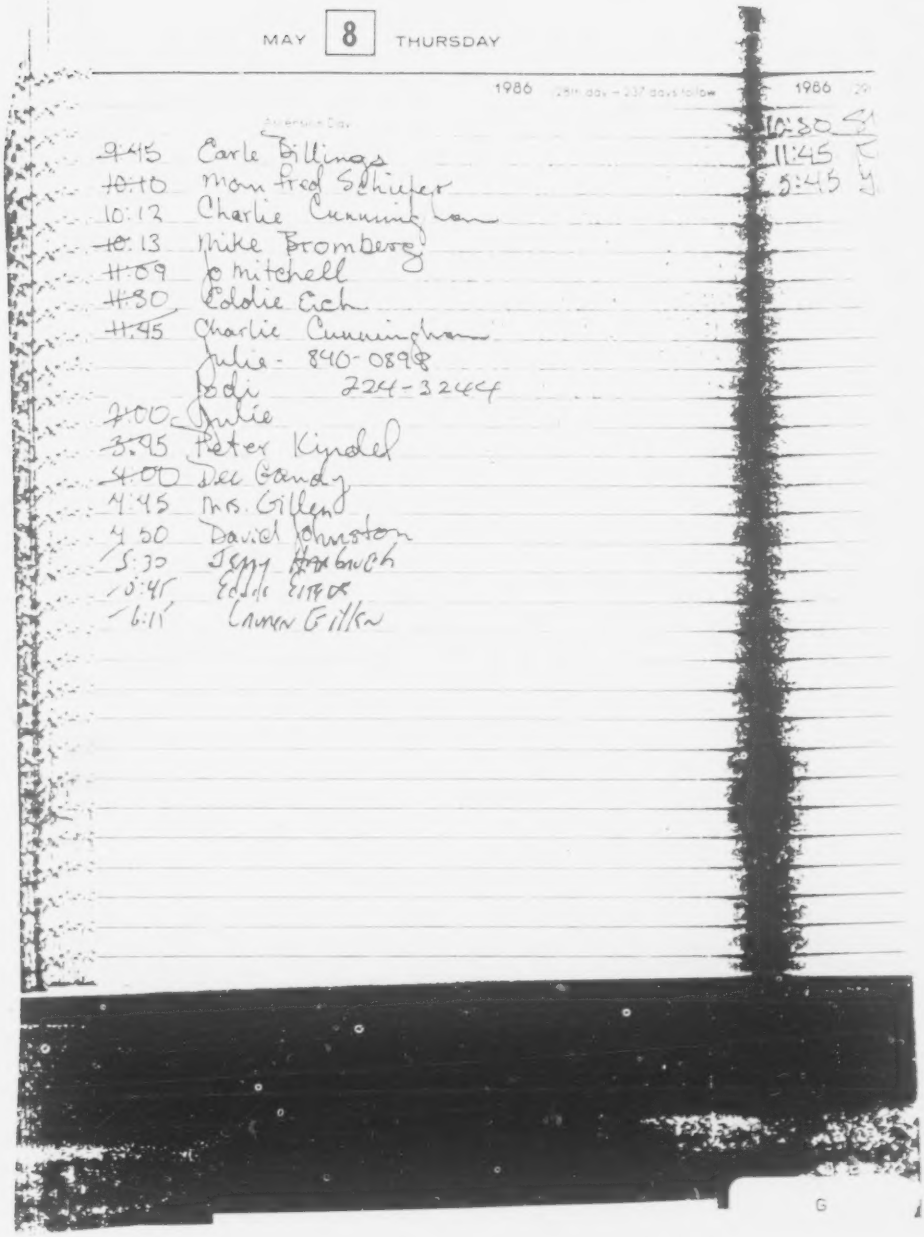
Loyd Hackler 783-7971
American Retail Federation
1616 H St, N,W,
Washington, D.C. 20006

Patrick J. Head (312) 861-6000
FMC
200 E. Randolph Dr.
Chicago, IL 60601

Philip F. Jehle 624-7828
400 N. Capitol St., #285
Washington, D.C. 20001

Rady A. Johnson (312) 856-7945
AMOCO Corp.
P.O. Box 87703
Chicago, IL 60680-0703

F



MAY 8 THURSDAY

1986 (281 days + 237 days to go)

1986

Armenian Day

9:45 Carle Billings
10:10 Manfred Schiefer
10:12 Charlie Cunningham
10:13 Mike Fromberg
11:09 Jo Mitchell
11:30 Eddie Eich
11:45 Charlie Cunningham
Julie - 840-0898
Eddi 224-3244
2:00 Julie
3:45 Peter Kindel
4:00 Dee Gandy
4:45 Mrs. Gilford
4:50 David Johnston
5:30 Jerry Hardwick
5:45 Eddie Eitel
6:15 Carmen Gilkey

10:30
11:45
5:45

American Cotton Shippers Association

MAIN OFFICE: [illegible]
WASHINGTON OFFICE: [illegible]

May 12, 1986

The Honorable David F. Durenberger
147 Senate Russell Office Building
Washington, D.C. 20510

Dear Dave:

Thank you for taking the time to attend the monthly meeting of the Washington Discussion Group, which sometimes resembles the "Gong Show".

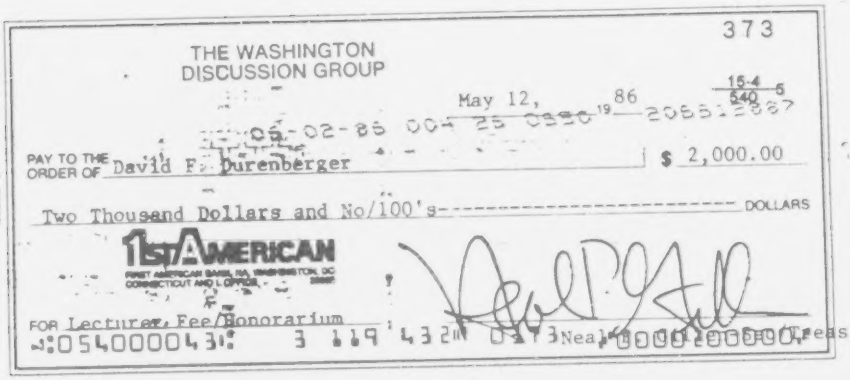
Attached is your lecture fee/honorarium for $2000.

Best personal regards.

Sincerely,

Neal P. Gillen
Vice President &
General Counsel

H



373

THE WASHINGTON
DISCUSSION GROUP

May 12, 19 86

15-4
540 5

05-02-85 004 25 0330 2085:2587

PAY TO THE ORDER OF David F. Durenberger $ 2,000.00

Two Thousand Dollars and No/100's---------- DOLLARS

1st AMERICAN
FIRST AMERICAN BANK, NA, WASHINGTON, DC
CONNECTICUT AVE. & L OFFICE
20007

FOR Lecture Fee/Honorarium

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1986

CHK NO	DATE	CHECK ISSUED TO	CHK AMOUNT	✓	DATE OF CHECK	AMOUNT OF CHECK	BALANCE
					BALANCE BROUGHT FORWARD →		12500
367	1/8	Thomas S. Foley Lecture Fee/Honorarium		✓		2000 —	10500
368	1/6	The George Town Club 12/18/85 Dinner		✓		1072 54	9428
	1/27		3340 —	✓			1272
369	2/3	Steven D. Symms Lecture Fee/Honorarium		✓		2000 —	10,728
370	2/3	Janice J. Whitten Lecture Fee/Honorarium		✓		2000 —	8,728
371	3/11	David H. Pryor Lecture Fee/Honorarium		✓		2000 —	6,728
372	3/31	The George Town Club 3/11 Dinner		✓		1,419 68	5308
	4/29		4197 50	✓			1110 96
373	4/12	David F. Durenberger Lecture Fee/Honorarium		✓		2,500 —	2,610 96
374	5/13	Spark Matsunaga Lecture Fee/Honorarium		✓		2,000 —	7,496
75	5/29	Pisces Club - 1-8-86 Dinner		✓		1,263 88	6,232
76	9/29	Thomas Hale Boggs, Jr. 2-3-86 Dinner		✓		1,069 46	5,163

3:59 to 5:30

4/29 Kathy Burke
8:00 659-0719
Williams & Jensen

G.D. Williams would like DD to give a $2K speech to tax clients on tax bill - any breakfast, lunch, or dinner in March -

15-20 people would be there

↔ corner of 11th & L St.
Suite 500
in Lafayette Square
— will call Kathy

OK

Currently Colonial Corp is in the Woodward Building. They will finance Transportation

↔ Landmark Building Red Brick.
Right before the Mayflower.

$2K is O.K.

SPECIAL COUNSEL HEARING EX. 202

A

PIRANHA

PRESS

Gary L. Diamond
Publisher

March 25, 1986

Ms. Kathy Burke
1101 Connecticut Avenue
Suite 500
Washington, DC 20036

RE: PROMOTIONAL APPEARANCE BY DAVE DURENBERGER

Dear Ms. Burke:

We have been advised by Senator Dave Durenberger's office that you have inquired regarding a promotional appearance by Senator Durenberger before Williams & Jensen on April 29, 1986.

As you were no doubt informed by Senator Durenberger's staff, we are the publisher and promoter of Senator Durenberger's book(s), and he has granted us the exclusive right to represent him in connection with all public appearances affecting the promotion of his book(s). It is in this capacity that we are contacting you and propose to enter into an arrangement for his appearance before your organization.

On behalf of Senator Durenberger we hereby consent to his appearance before your organization at the time and place specified in the attached schedule in consideration of the payment by you to us of the sum set forth in such schedule.

Your organization shall be responsible for making all travel arrangements and accommodations for Senator Durenberger. These arrangements must be confirmed through his office in advance. All payments must be made in advance and tickets delivered to his office no later than three days before the scheduled departure. All such arrangements must be satisfactory to Senator Durenberger and his staff.

Payment of the sums due us must be made to us within ten days from the date of this letter.

4504 EXCELSIOR BLVD. - MINNEAPOLIS, MINN. 55416 PHONE (612) 920-7711

B

Because Senator Durenberger's appearance before your organization will be in promotion of his book(s), we expect that you will make available to us adequate space at or near the entrance to the function at which Senator Durenberger will be speaking for the prominent display and sale of his book(s). We will provide all necessary promotional literature.

Due to Senator Durenberger's commitments before the United States Senate, we cannot guarantee his appearance and we may not be able to give you any advance notice of his changes in plans so as to allow you to schedule another speaker. However, in the event Senator Durenberger is unable to appear due to circumstances within his control, we shall upon your request, refund 100% of all sums advance by you to us.

If you have any questions, please contact myself or Jodi Mathison at Senator Durenberger's office (202/224-9477).

Very truly yours,

GARY DIAMOND, President

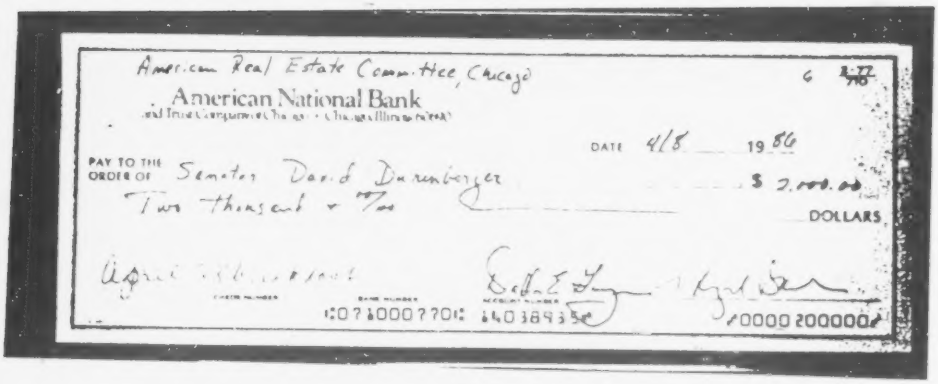
cc: Ms. Jodi Mathison
Ms. Kitty Gamble

C

APPEARANCE SCHEDULE

Date	Time of Appearance	Place	Amount
April 29, 1986	8:00 a.m.	Washington, DC	$2,000

D


American Real Estate Committee, Chicago

American National Bank

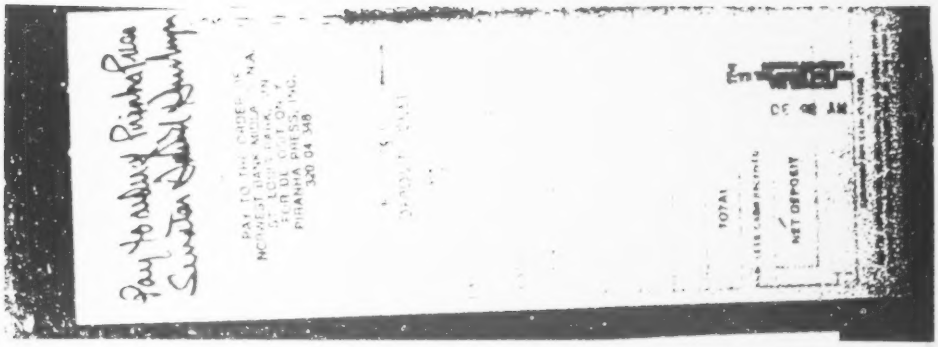
DATE 4/8 1986

PAY TO THE ORDER OF Senator David Durenberger $ 2,000.00

Two Thousand + 00/100 DOLLARS

April Installment

:071000770: 640389356 0000200000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114th Day • APRIL 29 1986
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Long Island
10 30
12 30
3 30
5 00
6 00
6-8
00

VOLUME IX

EXHIBITS 203–211

31-403 O—90——23

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording
Provided to the U.S. Senate
Select Committee on Ethics
by Senator David F. Durenberger

A. B. Laffer Associates

Client Breakfast

Economy/Budget

September 16, 1986

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SPECIAL
COUNSEL
HEARING
EX. 203

VOICE: I suppose that it is too bad that we had to schedule Secretary Lehman and Gary Hart back to back. On the other hand maybe that was a wise decision.

Just to go ahead with the program it is my pleasure to introduce Senator David Durenberger of Minnesota. Senator Durenberger has served since 1978 in the Senate and holds committee assignments in the Environment, Public Works, on the Finance Committee, Governmental Affairs, and the Select Intelligence Committee where he serves as Chairman.

Without further ado I am pleased to introduce Secretary Durenberger. Excuse me; Senator Durenberger.

(Laughter.)

SENATOR DURENBERGER: Maybe in another life; who knows. That is great. I read that bio. It is terrific. I am glad you didn't read it.

Arthur, it is a pleasure to see you. The last time I saw you was out at Palm Springs, wasn't it? You were dancing up the light fantastic, and we were both with 300 Republicans. I don't know what he was doing there, but -- oh, that is right. You were in the primary.

(Laughter.)

SENATOR DURENBERGER: Okay, well, I have a

---

variety of backgrounds. I chose to speak to you a few

variety of backgrounds. I chose to speak to you a few minutes today on things in general, and then to focus my comments around your questions.

If you think John Lehman and Gary Hart are good counterpoints, you ought to try me and Bill Casey. We have made an interesting duo over the last two years, and we sat together last week during the middle of the week, just as we periodically do, off in one of those sealed rooms chatting and sort of regaled each other with stories about how awful we have been to each other and the impression that people have that we don't get along when so famously we have done some wonderful things in the area of intelligence strategy that I would love to talk to you about at some length. You don't have the time today.

But a lot of people chuckle when they hear the words "Senate" and "intelligence" used in combination. It makes a great oxymoron like the Libyan Navy or Senate Intelligence or Senate Ethics which I used to be on.

But one of the interesting things about where you are today and some of the people you are going to talk to is that you are going to find, as I look through your schedule sort of hurriedly, you are going to find a lot of common philosophic bases even for the John Lehmans and the Gary Harts or whatever you may find.

There literally is not a lot of difference

between people who are sort of swimming upstream, not sure what direction they are headed, and have only their instincts and a little bit of their political or other history to guide them.

I came to the Senate as an accident. I think -- did Rudy Vashowitz speak yesterday? Well, we both -- we collided at the same time with history, two Republicans from the State of Minnesota. We hadn't had a Republican Senator in God knows how long, 30 some years, I think, and we elected two in the same year. Then in 1980 we elected 16 Republican Senators, people like Jeremiah Benton from Alabama, for God sakes. Who would think a Republican could win in Alabama?

Ronald Reagan, 70 year old movie actor. Things like that, you know, happen in this country so we were just sort of a couple of years ahead of the flow, if you will, in this country.

I take a certain amount of pleasure in having the opportunity to tell you that things are a whole lot better than they look when you view Washington from the outside, and the opportunity that Art has given me and you to come together this morning and share a couple of these thoughts should illustrate that we here are not that isolated as you may think. We are not that far apart from the realities of the heartland where I come from, as you may think.

I am an author, like Gary Hart, and I wish you wouldn't demean authors. There are too many books on the market. I realize that. Every day I get two of them in the mail from somebody. They don't sell a lot, but if you take time to read some of them, particularly those from politicians, with the advice of other politicians who know them, you might find some things about it.

I have my current book which doesn't sell really well because it is sort of a compilation of speeches like this -- is here, and it is addressed, "Arthur, I hope you enjoy these themes." This is a series of about 44 speeches that I had to put together in book form because I have been trying to write a book on health policy for three years, and I can't get it done because it is entitled "Health Care Reform Through Consumer Choice," and I am the reformist, and things are reforming so quickly and changing so madly that I -- the fellow that is helping me write it said, "Senator, you are not writing a newspaper. You are writing a book. Stop." And I can't stop. So we did this instead.

This talks about things like generational equity. I am also the national chairman of an organization I started, I will admit it, called Americans for Generational Equity, because I have been looking for a positive way to bring the generations in this country and the different economic and other interests in this country together around

issues like the deficit and ground water pollution and God knows what. You know, all of the things that plague us.

My generation is the first that is positively going to leave its children less well off than it was left by its parents. There is no question about that. I am doing that right now. I took the national debt from $800 billion to $2.3 trillion. I took the Debt Service from $49 billion up to $196 billion. I am saddling all of that on my kids.

I haven't got the money to handle acid rain. I haven't got the money to do ground water. I haven't got the money to do any of these sorts of things.

Now, there is some good and bad in all of that. Not having it makes us find better ways to do it, but on the other hand, the other side, you look at all the effort we put into income tax reform here, and all we did was reform the income tax, and all we did was start to reform the income tax. We never really got at the major tax on income which is the payroll tax and on which so much of the rest of the income security system of this country is built.

This year a lot of people in this country, certainly everybody in this room, will pay $6,000 per person per job per year into a Social Security system that won't be around for people under 32 years of age. The payroll taxes will have to be up around 27 percent at current rates and

current demographics to have a system there. In two years it will be $8,000 per person per job per year. Two people running families, which there still are a few two headed families. That is $16,000 right off the top.

You talk about the cost of labor, the cost of doing a job, the cost of creating an opportunity; $16,000, for the other end of the opportunity, 40 years later, generation to have.

So I don't want to try to prove that theory here this morning other than to say this book says a little about generational equity. It is also going to say a little bit about choice. I also started a foundation, getting it off the ground on choice, financing choice of public services.

I am one of those crazy guys that believes that in 10 or 15 years we will not have public hospitals. We will not have public schools; that is, Government run schools, and all the sort of public institutional delivery system that we currently take for granted, including some parts of the Pentagon, I would venture to say. I am not going to be a radical right off the bat, early in the morning. We won't have them.

We will have a concept of public education and health and so forth, but it will be largely built around accessibility and affordability. But the delivery system will be private, and it will probably be, I know in the

health care area, it will be for profit. It will be a for profit delivery system; and everybody in the country will have a plastic card which can represent an annual choice of health plans, the way people will protect themselves against the problems of illness or accident.

I believe that firmly because for five years, six, seven years now, I guess, I have been involved with financing consumer choice of health; turning the system around by reversing the incentives for the delivery of services, bringing competition and the marketplace to bear in health care. It will work in health care. I know it will work in education. People think that is crazy. I know it will work because I am a father. I have children, four of them. I have been a buyer, and I go to a marketplace even in higher education, which is supposed to be choice. I go to the marketplace in higher education, and all I find is books like this, from every college in the country, fancy books. Only the girls are different.

I have got four books. They look through to see what the girls look like on various campuses. The curricula are all the same. I mean, the titles are all the same. I know the programs are different at these colleges, but where is the competition? Where is the competition?

There is some competition between public and private, depending on your economic status, and the more we

ratchet down the financing of higher education, the greater problem we are going to have also because we will continue to fund the institution. If we aren't going to fund individuals, we are going to have some problems in this country.

But I believe you can flip that around and make it work differently.

Well, that brings me here to talk to you about the economics and the tax bill and things like that, and I have chosen to just say a few brief words to you this morning about evolution as opposed to revolution since I have been a part of it and to say that really the budget deficit, in my view, is the heart of the problem in this country today, and the problems that we face as a nation, nationally, internationally, I will face Thursday morning. I guess first we are going to go over and listen to Cori Aquino speak and then we will go over and mark up a trade bill.

Well, you know, can you imagine? We are going to adjourn by October 3 so we can get to the electorate because the Senate is in danger, and two weeks before adjournment date we are going to sit in the Finance Committee and mark up a trade bill. Does that really make any sense to any business person or professional person sitting in this room that we can make that kind of policy in that kind of period

of time? Well, of course, we are not going to make a whole lot of trade policy in this relatively brief, short period of time because our basic philosophy is still in evolution.

We are either free or fair traders, depending on how you, from whence you look at this, but regardless of what we do in terms of trade policy we are still captured by the problems presented to us by the predictability of the deficit and the consequent high dollar against everybody else's currency by which we were plagued from 1982 on.

Now it is, you know, things are starting to change. I am not an economist. I am not here to predict what is going to happen in the future, but I am here to say my beliefs, and that is the deficit is the biggest problem facing this country. The inevitability of deficits out in the future is the greatest plague on the stock market and on the international trade deficit and God knows what, and I refuse to deal with deficits in terms of percentages of gross national product or gross domestic product or any of that sort of thing.

I refuse to deal with the national debt in terms of a percentage of anything. I am a balanced budget person. I am a living-within-your-means person. I am a taking responsibility for your action person, and I cannot in this day and age -- maybe in the '90s I will accommodate to it,

but today I will not accommodate to not living within my fiscal means because of the past history of this country of sort of playing loose with our capacity to live within our means and our capacity to make political decisions that go with it.

So I have to, whether I am comfortable with it or not, I have to be a budget balancer. I am not a line item vetoer. That doesn't work. If you can't balance your budget, don't give anybody a line item veto because that just means one person gets to vote on what spending goes up. That is all. But if you have a balanced budget, then you can have a line item veto.

How do you get to a balanced budget? You have to spend money differently, and you have to tax differently, and you have to bring the two in line, and you have to restore a set of values to this country which are that somehow or other we are going to live within our means.

Now, literally live within our means? Should we have a Constitutional amendment to balance the budget? I don't think so, but I voted for it because I haven't got anything else to vote for other than the line item veto which doesn't do the job. So I vote for Constitutional amendment to balance the budget because I can't find anything else. I vote for Gramm-Rudman-Hollings.

In fact, the year before Gramm-Rudman-Hollings

there was Durenberger-Gordon, but that is too big a mouthful so we didn't make it, but we had the same concept laid out. It collided with the KGB, Kasavan, Grassle --

(Laughter.)

SENATOR DURENBERGER: -- which was the Rudy Vashowitz version of "If we cut everything by two percent, or if we hold the growth and everything to two percent, we can balance the budget." And we collided with that and lost and so the subsequent year we had to come back to Gramm-Rudman-Hollings which is a way to say, "If you don't cut the spending or increase the revenue or do some balancing act, the Veg-a-matic will get your constituents; and when the Veg-a-matic gets your constituents, you are going to be in trouble."

How do you learn to live within your means? By learning to live within your means. That is how simple it is.

And you take these things one at a time. You take defense, and you take health care, Medicare, Medicaid, and its various components, and you take all these sorts of things, and you set yourself a goal to live within your means, somehow or other.

VOICE: Is that likely to happen?

SENATOR DURENBERGER: Is it likely to happen? Sure, it is likely to happen. It is an inevitability, but

it will come with -- sort of near the tail end of the next Presidential term from the next President, whoever that might be, and there is no way I will even guess.

But the value system in this country has held up well while the programs have been sort of dissipated as a solution to these problems, and the value systems tell me that people want us to live within our means. For a period of time they thought the other guy ought to live within his means while they didn't have to. Now the consensus in a political sense is growing that we all need to find some way to adapt to it. That is what gave us this wonderful thing called tax reform, the idea of fairness and equity and everybody being treated the same, and the only reason we got to this wonderful Packwood, Rostenkowski, Reagan, Regan -- all the folks who want to take credit for it -- tax bill was when we cut the rates down to 25 percent and then edged them up to 27 and now to 28, and you know where they are going after that.

But by getting them down to that 20 percent, somehow we left the impression out there in America that the only way we could do that was by taking something away from somebody, and as soon as the things came out in the newspaper where you could figure out your own tax, at least half the people in this country figured out that somebody else must be paying more taxes because they were getting a

little tax break.

And so there is general support in this country for the concept of lowering the rates at the expense of base in the taxes. But is there any policy in it? There is political policy but not really good tax policy as far as I am concerned.

Political policy, simply this. It is phase two of 1981 tax reform. Ronald Reagan became President. Well, 20 years earlier when he made his first General Electric speech, I was around to hear one of those first speeches at a St. Paul chamber meeting, and I remember his talking about the income tax and what he didn't like about it. He said it is because it is like a mountain range, like this; and I am up here, and the guy next door is down there in the valley, not paying any taxes, and it is like that. From year to year you are up and down the mountain, but the average middle class guy is always up, thinks he is up on top of the mountain while everybody else is sliding up and down or sitting down in the valley.

So how do you approach that? Well, the guy that wrote the little editorial in U.S. News or Newsweek four or five years ago about flat rate tax, he captured it. He says the way you do it is, you bring down the tops of the mountain by filling in the valleys. That is the flat tax.

In 1981 we cut off the tops of the mountain;

brought the marginal rate down to 50 percent, cut all the rates by 25 percent, the accelerated depreciation, all that sort of thing. That was an effort to cut off the tops of the mountain.

In 1985 the President proposed filling in the valleys. How do you fill in the valleys? Go through all that pain and suffering, and the folks would have to pay some tax by promising the folks at the top of the mountain they would come down even closer to the folks in the valley, and that is what we did this year. Is there tax policy there? Not a heck of a lot, in my view.

Is there any way that you can look at the country's income tax, after we finish with it in a couple of weeks, and find out whether our philosophies have changed, and I would suggest no. Only the so-called fairness or equity philosophy has changed, but the basic tax on income philosophy has not changed because you can't tell the difference. Still, the main difference between consumption and investment is that consumption is favored over savings and investment.

We still have some of the explicit differences, but generally speaking the income tax, when you look at it and live with it year after year, does not tell you that it is better to save and invest than it is to consume, and that is because we can't give up our consumption. I mean,

America is now the great bazaar. Everybody brings their products from all over the world, and they come in here and dump their products on this wonderful market, and we can suck it up because we have had 30 years of appetite built up, and is it any wonder -- and our tax code has helped that along, and our tax code is reflective of this giant bazaar.

So try to change the bazaar by tariffs and duties and all that sort of thing? Forget it. Change your attitudes. Change your attitudes; slowly, gradually, get us to think saving. Get us to think investment. Get us to think jobs. Get us to think opportunity as well as thinking having.

There is nothing wrong with thinking about having, but when you have, think also about paying for it.

That is the next phase of tax reform. The income tax will be changed to reflect differences between savings and investment. There will be two different rates; one rate for consumption and another for savings and investment.

Following on that will come an explicit consumption tax like a value-added tax. There is just no question about it. When? I think 1991, '92, '93, somewhere in there, there will be a value-added tax. That will be used in part to reduce the principal on the national debt and in part on the payroll tax. And that is a political statement and not a philosophical statement, not a philosophical

statement or anything like that. It is a political statement.

The twin problems we are going to have. I listened to folks at the Minnesota State Fair and as I travel around the country, I hear, "Do something about the principal on the debt," and they are willing to pay some explicit tax if they know it goes to that. And I hear from more knowledgeable people, "Do something about the rise in payroll tax. Find some other way to finance Medicare, for example. Take part of your value-added tax and put it in Medicare financing. Do something like that."

Well, I would predict that the value-added tax comes after that. The rates will stay low on the income tax, and I think that is appropriate for all the reasons that Arthur and others have been lecturing to us for God knows how many years.

One good thing about the tax bill, I guess, is that now people have more economic incentives for their investments than they have tax based incentives and so over the next couple of years we are going to learn how people use those economic incentives and how they view the absence of the tax based incentives.

But the problem is, there are still some folks got tax based incentives, and over a period of a couple of years we are going to figure out who they are and where the

money flows, and then we will probably close those up as we move toward more economic based incentives.

But just changing the tax code doesn't do the job. That is my bottom line in this presentation. Just changing the tax code doesn't do the job.

Trade policy, fiscal policy, health policy, housing, a whole lot of other things that this country doesn't now have. A national security policy which we do not have.

Every President who comes along has a new view on things, and he brings a bunch of tigers like old Johnny Lehman in here, you know, and we have one sense of what our national security policy ought to be.

In two years that is going to be gone. Already it is starting to fade. People are waiting for Ronald Reagan to leave and Lehman to leave and all that sort of thing, and there will be a new national security policy articulated by whom, what? NSC, State Department, Defense Department; who? You can have a national security policy. We did it. We are doing it, Casey and I. We have a national intelligence strategy. We have built it last year. This year we are building on it. Now when we go to budgeting and things like that, and everything is at a mission state. It is not line item any more. It is in a mission state.

If you are going to cut into intelligence, you

are going to degrade which mission? Counter-terrorism, fighting drugs, arms control monitoring -- you know, all mission oriented now.

Barry Goldwater and Sam Nunn have set up Armed Services to do the same sort of thing. John Warner is going to walk in there with a strategy, a strategy, and one of these days we are going to combine these various strategies in defense, intelligence, and the political, State Department, and so forth, in a national security policy, and I know it is coming. I am going to be a big book; the printed word to pass on to two point whatever it is billion people, but there will be a sense of policy and a sense of strategy in this country in all of these areas because that is the way Americans are beginning to think. They want some goals and objectives. They want to judge us on how we march toward those goals and objectives. We are no longer measured on problems that we solve in the immediate sense, money that we spend in the macro sense.

Political problems in this country today are basically apathy. It is not a problem necessarily if you are a politician. If you are a voter -- apathy, and the nice thing, though, the good thing is that people are getting the impression that not all problems can be solved by politicians. It is just starting to sink in, and you will see that in the '86 election. Hopefully, you will see

it in the '88 election because I have to run against Hubert H. Humphrey, III, I think, to retain my seat which I took from the father when he died.

But the reality is out there that folks have decided that some of these problems are so big that they just can't be handled like that in Washington or by politicians, and that is an opportunity for you to come and participate in these kinds of sessions, input into us. So now is your opportunity to beat up on me.

Yes?

VOICE: Would you comment on the speed of the exchange for Nick Danilov?

SENATOR DURENBERGER: The problem in the Danilov case, and obviously I have some problems. This isn't my marketing strategy, I mean, but I have some problems in discussing all of them. The information we have on it is that the Russians have circumstantial evidence that Nick Danilov participated in what they classify as espionage. There was little hint of that in both the New York Times and Washington Post on Sunday, alleging that he had some kind of a relationship with a CIA station chief or somebody else, and the reality is that journalists in the Soviet Union get used by dissidents or people like that in one way or another to pass messages. I would suspect that Danilov has been used in that regard. I know he is not a spy. I mean, we

all know; while we don't have statutory prohibitions against using journalists, this country just, you know, isn't in that business for the reasons that this case points out.

But they do have grounds. What do I suspect is going to happen? They are going to reel out their information, and at some point in time we are going to trade for Sakharov, even though we are going to bite our tongues and grit our teeth. You know, having lost billions dollars worth of God knows what through Whitworth and Walker and all the rest of this crap that has been going on, it is really hard to give them back a spy.

This guy will be justified in this case, I think, in this case because this guy didn't really get a lot of secrets. He was being fed stuff. The young man he was working with had come to the FBI early on so he wasn't getting real stuff, but he is a real spy, and they have got 100 and some of them in this country up in New York, and they have got a little under 100 right here, and we know they are spying. We watch them. Our counter-intelligence is pretty good. We don't roll up all the people that we could roll up.

If we treated every Soviet in this country the way they treated Danilov, we would throw out half of the Soviet mission at the UN and half of their --

VOICE: Why don't we?

VOICE: Why don't we?

SENATOR DURENBERGER: I think we don't principally because this is sort of like the mutual assured destruction pieces of nuclear arms, and that is our opportunities to use diplomatic spying around the world are so refined that we don't want to put a crimp into the Soviets doing the same thing, and that is a statement that the community wouldn't make, but it is sort of a statement looking at the way the community has operated over the last eight years.

They believe that we are better off if we can control those couple of hundred people. Now what we are trying to do is reduce the number, and we have very few people over there. The Moscow Embassy in the United States is full of Russians. I mean, we have got Russian typists who are spies. We have got Russian telephone operators who are spies, and all that sort of thing. We can't get rid of that because of the State Department, and their argument is to move people over there.

I don't want to sound like Jesse Helms here, but reality is, it is hard -- so we are trying to reduce the numbers. That is sort of our solution to this problem. Reduce the numbers of Soviets to a parallel with the number of Americans that they have permitted, and by doing that, we accept the burden of counter-intelligence, and we are very

good at it, and we are getting better all the time. We can improve on it, but we aren't hayseeds when it comes to counter-intelligence in this country.

Yes, sir?

VOICE: Senator, does it serve the United States' interests to treat terrorists who capture Americans and hold them hostage different when they are Soviets versus when they are from the Middle East?

SENATOR DURENBERGER: I suppose it does, only because there is a different kind of a relationship with the Soviet Union than there is with some Shiite family out of the back hills of Lebanon that is just bound to blow up Israelis wherever they can find them, Americans wherever they can find them.

VOICE: Some people have suggested that it is typically because we are afraid of the Soviet Union and what might result if we would confront them over an incident like Danilov.

SENATOR DURENBERGER: No, I think the problem in Danilov is strictly the one that I alluded to earlier, and that is, they didn't just pick up a journalist to trade off against Sakharov. They had some, what they in their system would consider evidence. It looked to us like flimsy, circumstantial evidence that could get blown to hell in an American court, but if you read the Soviet definition of

espionage, you wouldn't travel in the Soviet Union or you wouldn't talk to Soviets when you travel in the Soviet Union, and you know why your Intourist guide and so forth is, you know, listening to whom you speak and about what you speak because their definition is a tough definition.

Let's see if anybody else has a question.

VOICE: Senator, if I heard you correctly o the subject of a line item veto, we shouldn't have one now because the budget isn't balanced, and when we achieve the balanced budget and don't need it, then is when we should have a line item veto. Can you speak to that a little further?

SENATOR DURENBERGER: Yes. The line item veto comes out of the Governor's offices in 50 states in which they have a constitution in most of the cases which requires that the states' budgets, revenues and spending, equal each other at the end of the session.

In that part of the process then you make the Governor a partner with the legislature in the process of budgeting, and having been there, I understand a little bit about how the process works. The Governor very judiciously uses this line item veto to poke and probe the legislature into moving in ways that will operate to implement his budget recommendations, and when they go off the wall and do something that he has warned them he doesn't want, he uses

programs and little pieces of instructions and so forth that he gives the legislature.

To adapt that to the national level would be appropriate, in fact, if the main problem we had was not the budget itself. If the budget were not a problem, and even if we were running a small deficit or something like that, if that weren't perceived to be a big problem in this country, I would say no problem giving it to the President.

But if you give it to him today, there isn't much he can cut. I mean, he is not going to cut out one of John Lehman's ships. He may cut into the DRG reimbursements or something for hospitals, but he is doing that already through OMB. But none of us can really find what he can do other than cut out my program. If I won't support him on Nicaragua, here or there or wherever the case may be, he is going to cut out something that goes to Minnesota through some public works program --

(End Tape 1, Side 1.)

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Tax Reform--For You,
Company, Family, Employers, Industry

Weissman, Gepphardt

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SENATOR BOREN: So that's what the fight is all about. And that's why some of us on both sides of the aisle -- Senator Hollings and I have been the principal Democratic sponsors of this measure, along with Senator Gramm and Senator Rudman -- feel so strongly. We want to hold Congress' feet to the fire in terms of this debt limit extension, until we put in place some mechanism that will force us to do our job.

So as I say, it's impossible to explain to you what's going on in Congress; but perhaps this is a little indication. And I hope that this group above all would help us keep our eye on the ball as we talk about tax reform or tax change. And that is, to make sure that whatever we do increases and improves the competitive position of this country, in terms of world trade, and in terms of being able to compete for our own markets here in the United States.

Thanks a lot for letting me come by and talk to you this morning.

(APPLAUSE)

MODERATOR: The Senator says he can stay for a

few moments. He's got to head back -- they're going to have some more votes this morning. But because of your interest and involvement in both international trade and small business, I'd like to ask members of our panel to direct questions to you on either of those subjects.

PANELIST: I would like to just amplify, Senator. You said you favored a minimum tax. I'd just bring up a situation yesterday. There's another industry you alluded to in your state besides farming, and that's oil extraction.

SENATOR BOREN: Yes.

PANELIST: I was dealing with an Oklahoma oil company. And based on the current proposal for minimum tax in the House, and the fact that you can't offset --

SENATOR BOREN: Oil, gas --

PANELIST: -- investment tax credits --

SENATOR BOREN: Right.

PANELIST: -- whatsoever, their tax bill is going to go up from 4 to 80 million dollars.

SENATOR BOREN: That's correct.

PANELIST: I would suggest that that is going to hamper capital formation, let alone your industry in that.

SENATOR BOREN: Oh, you're absolutely right. And there are minimum taxes, and there are minimum taxes. That's the reason I explained a little bit about my own proposal. It probably would not surprise you that my own

treatment of such items as intangible drilling expenses is a little different than that in the --

(LAUGHTER)

SENATOR BOREN: -- in the recent Ways and Means proposal. And that can be very serious.

I think it's one thing to say -- and I've tried to explain this on the Senate floor because, as I've said, I do believe in incentives; I think they're absolutely appropriate. And when we were debating Treasury I, we had an Assistant Secretary of the Treasury. I had a group of Oklahomans fly up, independent oil producers. Someone told me it was the largest flight of eagles ever organized in Oklahoma, that flew up for a meeting with the Treasury. And they were not happy eagles at all, either. Some of the pens got sent back, even.

(LAUGHTER)

SENATOR BOREN: But they were saying, "Look, we cannot continue." And with oil prices falling -- I think all of you know exactly what has happened. In my state, three years ago we had almost a thousand rigs drilling for oil and gas in the state. Today, we less than 250. Some of our banks are among the largest drilling contractors in the world.

(LAUGHTER)

SENATOR BOREN: But it's a terrible shock. And

what it's going to do in the long run, again, is drive up our dependence on foreign oil, which again drives up our trade imbalance. Almost half of our trade imbalance is due to imported energy products, principally oil.

So that's a real problem. And I remember the person who came from Treasury said to them -- which, it was very interesting for me to watch their reactions -- they said, "Look, if you people can't get along in this country without some incentives --" they called them "subsidies," like depletion and tangible drilling cost deduction -- "we shouldn't have a domestic oil industry in this country." That's the way they said it, up front.

They used the introduction to Samuelson's "Economics One," freshman year --

(LAUGHTER)

SENATOR BOREN: -- and said, "You know, we have comparative advantage, and if we don't have a comparative advantage in energy production in this country without some incentives in the tax code, we shouldn't be producing it. We should let the money now being invested in that industry recycle through the economy until it lands someplace where we do have a comparative advantage."

No regard to national security. We don't even need to keep the refining capacity sufficient to refine what's in our strategic petroleum reserve -- and by the way,

we're almost down to that level in terms of refining capacity right now, and if we had an emergency, that oil we put down in the ground, it's doubtful if we have the refining capacity to even refine it quickly enough to utilize it in times of national emergency. It's just incredible, you know.

So I think that with a minimum tax what you want to do is not destroy basically -- you know, give with one hand, and totally take away with another. These incentives, whether it's those that you've mentioned, which are near and dear to my heart, or others, were put in place for basically good reasons.

I think what you want to do then, however -- you've got to avoid this problem of an odd combination of preferences that some company might have coming together, where you not only maybe have zero tax, but get a big rebate. Because that's what causes anger out in the country: The speech on the floor of the Senate about the little old lady in Milwaukee making $16,000 a year who was waxing the floors at night for some giant corporation that was making $2 billion -- she was paying more taxes than they were. That is the kind of thing that ignites political activity, and it's the kind of thing that you just cannot defend and still keep voluntary compliance with the tax code.

So I think that what we have to do is, set a minimum tax at a rate and a level and in a way that is fair, that recoups a small portion of the incentives so that the company pays some tax, but doesn't recoup so much that you in essence take away the whole advantage of the incentive and make it impossible for those industries to operate.

That's a careful balance that has to be struck, and it's a balance that the Ways and Means Committee proposal thus far totally fails to strike.

So I think there are minimum taxes, and there are minimum taxes; and mine's good, and theirs is bad, just to bring it down to the bottom line.

(LAUGHTER)

MODERATOR: Time for one more question.

PANELIST: Senator, I have a question that small business people are interested in.

In the Administration's and Congress' zeal to get after those people who are abusing the system --

SENATOR BOREN: Yes.

PANELIST: -- I think they're going to create a blizzard of paperwork --

SENATOR BOREN: Oh, yes.

PANELIST: -- for already burdened small business people. Could you comment on that?

SENATOR BOREN: Yes. Oh, I think that we have to

be very careful about that. We have a number of initiatives that have been put forward by a number of groups. They include small business. I appreciate you bringing that up -- the NFIB and others -- in terms of allowing businesses under a certain size to simplify and to avoid a lot of this.

This is another problem with massive changes as they get underway, that it seems to me that I have yet to see any change billed as a reform or -- well, everything's always billed as a reform in tax change -- that ended up simplifying the tax code any more or reducing the paperwork burden on small businesses.

So you're absolutely right. And in addition to the items I mentioned, certainty, which I think is one of the first elements -- you know, what is a tax code? Well, it has to have fairness, we mentioned a perception of fairness. It has to have certainty, so you can make the long-range investment decisions. It has to help us compete in world trade. And certainly, the other item which you mentioned, it must have enough simplicity, and it must -- it must keep in mind additional burdens of reporting and record keeping that it impacts.

And I hope before we pass anything out of the Finance Committee, we'll sit down and measure that, put that yardstick up and say, "Okay, what we've passed, or are getting ready to pass out, what does that do to paperwork

burden on small business? What does it do to international competitiveness?" And really sit down and in a thoughtful way measure those impacts, before we put it out.

MODERATOR: Senator, thank you for coming.

SENATOR BOREN: Thank you very much.

(APPLAUSE)

MODERATOR: We're coming down to the home stretch, here. And last, but certainly not least, of our official guests this morning, we have with us our distinguished friend from Minnesota, Senator David Durenberger.

Senator Durenberger is known by his colleagues as an exceptionally able, thoughtful, and hard working legislator. And I can tell you, having had the opportunity to spend a few moments with the Senator earlier this week, that I agree with all those feelings.

Senator Durenberger has become the Senate's leading authority on health care, and carries a heavy responsibility in these perilous times of being Chairman of the Select Committee on Intelligence.

As a member of the Tax Writing Finance Committee, he'll play an important role in determining the shape and timing of tax reform.

Senator Durenberger, it's a distinct honor for me to welcome you to the platform this morning.

(APPLAUSE)

SENATOR DURENBERGER: Thank you very much.

Dave Boren said he was going to listen to my introduction and escape. I'm sure I've got the same introduction, but a different state, that you've got.

(LAUGHTER)

SENATOR DURENBERGER: I am befuddled by the topic we're supposed to speak on: tax reform. We haven't spoken those words in the Senate in a long time. We're dealing with something else, and I brought it along because I had to preside from quarter to 9:00 until 9:00 this morning.

What we've been spending a lot of time on is something called H.J.Res. 372, which was reported from our Committee on Finance on September 26th, which is legislative day September 23rd, 1985, by our chairman, Mr. Packwood, without amendment.

"Resolved by the Senate and the House of Representatives of the United States of America and Congress assembled that Subsection B of Section 3101 of Title 31, United States Code, is amended by striking out the dollar limitation contained in such subsection and inserting in lieu thereof --"

and I hope I get this right -- I wish I didn't have to --

"-- 2,078,700,000 on and after October 1, 1985."

So I will speak to the subject of tax reform --

(LAUGHTER)

SENATOR DURENBERGER: -- but I want to tell you, that this is about all that's on my mind today: $2,078,700,000, which will cost my four sons 24 times that. And I haven't even wanted to figure that one out: what is 24 times 2,078,700,000.

I know that already what Dave and I are doing this year, by way of adding to the deficit, will cost my four sons $10,000 off of their taxes. Just what I've added this year. I've sent them a $10,000 bill automatically, because I have been unwilling to match my appetite to my ability to pay.

I had to start out that way, just so you understand the difference between some parts of this place and others.

I assume Dave made some comments about the deficit, as well. You can tell it is not a partisan issue. You ought to thank God that, despite the fact that we sound partisan in this place, and we read partisan -- "R-Minn.," "D-Ok.," "OK," Oklahoma, whatever it is -- that this is one issue on which the verbiage may come out partisan, but the problem is strictly a generational problem, strictly a generational problem.

I was born -- and this you're going to find hard to believe -- I was born in 1934.

(LAUGHTER)

SENATOR DURENBERGER: The middle of the depression, when I was all my folks could afford to have. And my folks and their generation, the Hubert Humphrey, lots of other folks, generation -- Hubert came out of South Dakota, and his dad went broke and, you know, all this sort of thing. When they came, they swore, in that period of time, when they were having the "me's" and the other folks, they swore that our generation would never have to live through what they lived through.

And so, when they came to political power after the Second World War they created having without paying for it. And for 30 years, my generation has been the beneficiary of that legacy -- a very well intentioned legacy: You shall never have to live through a depression again, my son.

They gave me the $500 home, which I took from my first home of $8,500 to -- I kept recycling my 500 bucks until the last one I sold in Minneapolis when I got elected in 1978, bought it for $75,000 in 1972, sold it for $249,000 in 1978.

They gave me free health care. They gave me the notion -- they raised me on the notion that it was better to be sick than it was to stay healthy. When I went to work, they gave me something called a health insurance plan, which

was my guarantee that, any time I got sick, I could have the best doctors and hospitals in the world, and it wouldn't cost me anything.

They told me that my employer would pay me to go to the hospital. My friends would send me flowers and candy -- but if I stayed at work, stayed healthy --

(LAUGHTER)

SENATOR DURENBERGER: -- no cards, no flowers! You know, just work, work, work.

(LAUGHTER)

SENATOR DURENBERGER: So in 30 years I have priced my children out of housing. I have priced a lot of Americans out of adequate health care, or at least I've raised the bill to everybody for adequate health care. And I am now about to leave them not only the legacy of $2,078,700,000 added onto by $200 billion a year, at $24 in repayment for every one dollar that I have to have today, but in actuality a total debt of $7.1 trillion in this country at the end of 1984, growing at the rate of $1 billion per year. An insatiable appetite to have, without paying for it.

So if I put tax reform in that context, you know, I say we've got two forces going here that are not in the real world. We have a President operating off of my parents' generation's theory that you can have without

paying for it; you don't have to pay taxes in this country, because all they do is go to government that wastes it. So get that rate down just as far as you can, because government's bad, and so is everything else that goes to support it.

Operating off of 1960 General Electric speeches, and trying to put them into effect. And for four years, it worked terrific. Cut spending, cut taxes, cut regulation, all of that very important. And it worked to turn this country around.

But now, this is a country of the '80s, not of the '50s or the '30s. And we need to deal with it in that kind of a context.

You have Dan Rostenkowski trying desperately to hang on for the Democratic Party to the last remnants of what they believe is the middle class in America. And again, Dan senses the same need to appeal to my appetites, rather than to my responsibility.

And yes, on occasion you'll hear somebody say, "Oh, our children this, and our children that," and all that sort of thing, but they're playing to the middle class: Hang on to the middle class. Make sure that they believe that they're the ones that are being gouged by health insurance, they're the ones that are being gouged by the tax collectors, they're the ones that are being gouged by

everybody else in this country. Tell him, my generation -- it hasn't had enough. You know, we ought to give them more.

And that strikes me as being part of the problem. When you sit out there and you read your home town newspapers and you watch television, and you wonder, "What the hell are those guys doing in Washington? They aren't in the real world," the reality is that they are in -- we are in, each of us, our own real world.

And it is how we deal with our perception of those real worlds, applying it to the realities of the '80s, that is going to mean success or failure to this great turnaround this country is experiencing attitudinally here in the early part of the '80s.

Now, even though we may have different views of where we're going and how to get there, I am an eternal optimist. I know, by the end of this decade, or the beginning of the next, this country will not only be turned around, but it will be clearly marching off in a new direction.

Unfortunately, it's going to take us five years to get there. Unfortunately, we're wasting a 49-to-1 lead, you know, as Republicans, which we took into the locker room at half-time last November, we're wasting a lot of that right now. We're not playing off of it. But at least it was 49-to-1. Nobody can take those 49 points away from us.

And we have got this place turned around, and we're going off in a different direction.

I'll just conclude my formal remarks on tax reform --

(LAUGHTER)

SENATOR DURENBERGER: -- with this. You need to know where all of us come from.

Could I have a little water? Hard to get to bed at 3:30 in the morning and wake up at 7:30.

And I'm sure that's why you invite policy people from Treasury, and very bright House members -- and adequately bright Senate members to speak to you.

(LAUGHTER)

SENATOR DURENBERGER: I'll say this about tax reform. We need it in this country, very much.

I need to focus on something other than this, because part of this problem obviously is -- this is the spending figure, and there ought to be -- well, this is the excess of spending over, whatever it is. But we ought to deal with our capacity to tax ourselves in a fair way for what we need.

So even though I say we are concentrated on deficits, we also desperately need to get about the job of tax reform. But if we're going to do it, we ought to do it in some context in which society can participate with us in

a knowledgeable kind of a way.

To me, tax reform means tax reform. It doesn't just mean income tax reform. After all, taxes are that portion of my earnings which are committed to satisfying my own and other people's needs in some collective societal fashion. It takes place at the state level, the local level, and the federal level. It isn't just the national tax system that we deal with in this country.

So I'm all for tax reform. And I'd be willing to start just with the part that I have some control over, which is the national tax system. But the biggest tax in this country is not the income tax. The one that is growing by leaps and bounds is not the income tax. The one that causes the sharpest pain, that is the most unfair, the one that is the least productive, is not the income tax.

It's the payroll tax. It's the tax on work. It's the tax that today takes $5,400 out of you and your employees every year, every person every year, $5,400 -- just like that. In four years, it will be $8,000. By the end of this century, it will be $12,000. That's the price of employing an American worker today.

And we complain about -- "Gee, you know, we have $12 an hour jobs compared to the Taiwanese $2.00 an hour job." That's not the level to complain about. It is where we put this tax system in this country that is the problem,

because on top of the social security tax of $5,400 today, you have to pay unemployment compensation taxes to provide for another societal need. Then, on top of that, you pay workers compensation taxes, to provide for a third need.

So that mountain gets pretty high before the guy gets his first buck on which we can then levy something called an income tax.

So a national tax system is much larger than the income tax, to begin with. But if we keep ourselves concentrated only on the income tax, which is where the President wants to go, because that's the one that everybody perceives to be unfair, and we take notions like simplicity and fairness and growth, that still doesn't help us write a tax bill.

I don't know what Dick Gephardt said to you about the difficulty of writing a bill such as they're going through now. But to me, the difficulty would be that I can't measure a 75 percent reduction in the lunch tax, versus whatever it is they did yesterday. I mean, this whole myriad of things -- I have nothing to measure it against, other than, is it simple?

Well, gee, I don't know. What's simple to me may not be simple to Bob. He works in New York, I work in Washington.

Is that right? No.

PARTICIPANT: I haven't checked with my office.

(LAUGHTER)

SENATOR DURENBERGER: Okay. What is growth? What is growth? I mean, there are as many definitions of growth as there are folks in this room. And what is fair? Oh, my God. Let's not get into that one. But those are the principles on which income tax reform in this Congress is being based.

Let me give you an alternative set of principles. If we're going to tax income, if that's what we're talking about, why not try this as a principle. I work or I invest to earn an income, for what purposes? First, to satisfy my personal needs as a human being. I need a roof over my head, I need food on my table, I need health care of some kind, and I need to provide for the education of my family. Some basic needs.

Now, some of my dollars that I earn have to go to that purpose. So if you're going to tax my income, you ought to consider the impact that that tax has on the decisions I make about my basic needs.

Secondly, related to that, I work so I don't have to work all my life. I work in case I can't work all my life. So a certain part of my income is my rainy day fund. I set it aside. I used to put it in a shoe box, or under the floor in the kitchen, or something like that. In case I

was disabled, and when I retired, I had something set aside.

So when we levy an income tax, particularly a national income tax, ought we not to consider its impact on our decisions about income security?

Third, how do you run a country like this without my committing some of my earnings to somebody in this room to build a better America, provide me with greater resources, expand my productive horizons? Capital investment. Unless you can get it out of a bunch of us, and put it into a bunch of you who are willing to take some risks, how do we keep this country going? So capital investment.

What I take from my income to commit to productivity and growth and research and development is going to be very important. So how government taxes my income devoted to those purposes is very important.

Fourth, I have to commit a certain amount of my dollars to meeting the needs of education, filling potholes, police services, things like that, most of which are delivered at the state and local level. I pay an income tax, a sales tax, and a property tax in the state of Minnesota that's very important to me, very important to me. And how that part of my income that is committed to my local school, and to my local cop, and to my sewage treatment plant, and all that sort of thing, in Minnesota, and how the

national government taxes that part of my income, is very important to me. It's important to us as a society.

And fifth, the fifth purpose I guess is all other. It's consumption. It's the one that my parents' generation decided it was going to put in all the freebies for. The one that said the way to rebuild America is to have everybody consume: recycle your car every three years, you know, on and on and on and on and on. So we used the income tax mainly to get us all to suck it up as fast as we could. Now, that's the fifth purpose. It may be a very legitimate purpose.

But ladies and gentlemen, let me conclude my remarks on tax reform by challenging you, as I challenged some members of your board the other evening, as an association, as individuals, as people who have responsibility for the lives of other people and the futures of your children, like I have responsibility for my children, to think in terms of principle. Not shibboleths, not the things that grab for some class of people in this country, but think in terms of basic principle.

If you, as a driving force in this society, handed me the charge as a member of the Finance Committee to reform the national tax system, having in mind those principles that I just went through, and you said, "Use those principles, Senator, as you go about the R&D tax

credit and as you go about depreciation and as you go about 401Ks and all the rest of that sort of thing" -- that's the greatest gift you could give yourself, is to give me that kind of principle to work on.

I'm not getting it from the President. Nobody's going to get it from Dan Rostenkowski. Dave and I can only get it from you.

Thank you very much.

(APPLAUSE)

MODERATOR: Thank you.

As I announced early this morning, our format is set and it is immutable. And that is, after the formal remarks, questions from the panel.

But as some of you in the audience know, I'm self-appointed, ADAP's answer to Andy Rooney, and I change rules from time to time. And so instead, I would like to throw open questions from the floor to the Senator.

PARTICIPANT: Yes. Many of us here are small companies and are chief executive officers or presidents of our own companies. And we don't believe that our employees would be willing to vote on cuts at various points in time.

Would you support the President having the ability to make cuts arbitrarily?

SENATOR DURENBERGER: The question is, would I support the ability of the President to make cuts

arbitrarily. I take it, you mean that in spending, so-called spending cuts?

PARTICIPANT: Yes.

SENATOR DURENBERGER: If that takes the form of something like the line-item veto, I would support the line-item veto, if we also had a constitutional amendment to balance the budget. If we were set up just like the states are, where you have to balance your budget, and the governor then uses the line-item veto as a lever to make sure that the people in the larger sense are being represented, while the people in the specific sense are coming through the legislative process, then I'm all for it.

Absent a constitutional amendment to balance the budget, or some other mechanism requiring the President to submit a balanced budget, I wouldn't support it. Because then it will just be used to leverage my vote on a particular issue.

Yes?

PARTICIPANT: Yes, the legislation, which I gather has been on the front burner, like, the wee hours of the morning, to drive us towards a balanced budget in the next five or six years -- what's your prediction? Do you think that finally is going to be passed in both houses and go to the President?

If not, what seems to be the problem that we

can't come to grips with that and get behind it?

SENATOR DURENBERGER: Great. The legislation, the Gramm-Rudman proposal, will pass this afternoon at about three o'clock, approximately. So if you haven't got anything to do then, and you can get in the gallery, come on up and -- you're not supposed to cheer, but you can when it passes.

(LAUGHTER)

SENATOR DURENBERGER: And hopefully, it will pass by more than a 53-to-47 margin. And I say that because a lot of guys like Dave Boren are in a trap. You know, because -- the first time we balanced the budget in the Senate was on May 10th, and Dave couldn't vote with us. It was only a 50-to-49 vote. But he had both of his arms being broken behind his back, and only one Democrat escaped to vote to balance the budget -- that time, in 1990.

You would have had -- if the President had gone along and the House had gone along with the Senate budget resolution -- you'd have had a balanced budget guaranteed, without any tax increases, by 1990. But we had to cut into social security, and we had to cut into civil service and veterans and a whole bunch of things to do it; but we got 50 people to do it.

So the Senate is really not a large problem. We'll pass that, and then it'll get homogenized by a variety

of special interests, I'm sure, over the course of the next week or so, because we have to extend it for the debt ceiling for a week or two, something like that, in order to get the House back from their recess, which they're taking some time today.

So that'll pass. Then, what you're going to have is a five-year process of everything being legislated on the budget. Everything is going to get tied into the budget process. And there will be three dramatic points during the course of each year, when the whole country will focus on the process, Senators will stay up late at night, they will come in weary to these speeches and late and things like that --

(LAUGHTER)

SENATOR DURENBERGER: -- and everything will be done in these three periods of time. And it will all be done in the budget context. That's not good; but it's the only thing we've got going. And it broke down last January, when the President gave us the budget that had a deficit in 1988 of $144 billion. And when he gave us that, we just said -- "You know, you don't look at this the same way we do."

PANELIST: Senator, can we realistically balance the budget without looking at the defense budget in a hard way?

SENATOR DURENBERGER: No, you can't balance the budget by just cutting spending, or just raising taxes. Because if you just raise taxes, you're going to take -- all of the incentive for reform disappears. If you just give us more money, we'll find more ways to waste it.

So you can't do that, and you can't just cut spending. The $215 billion deficit exceeds the amount of all other government spending, since social insurance, defense, and debt, all total up to like about $770 billion, and the total spending is 960. You know, you aren't going to make it if you abolish the whole of the federal government other than defense.

The only way to handle defense is to reform the whole system. And for those of you who are interested in reform, there are a lot of members of the caucus. I'm one of the few who has written a book. It's called Neither Madmen Nor Messiahs, and it tells you how you need to change this system.

But you don't do it just on procurement. I mean, those of you who sell to the government know that all we do is add auditors when we decide to change the procurement system, all we do is add to the paperwork, the procurement, and everything.

We've got tc ask ourselves some basic questions, like, you know, who are we likely to go to war with? If

it's Russia, then what's the difference between us? We're an island nation; they aren't. What does that tell you? Why do we have to have four air forces in this country? Which we have.

You know, there's a whole set of basic questions that you would ask yourselves, but they will not ask themselves in the Pentagon. And that kind of reform is essential. And I think Barry Goldwater and Sam Nunn sort of announced the other day -- I'm off here as chairman of the Intelligence Committee. We're working on a whole new approach on the intelligence side, which is to develop -- not for us to develop, but to have the Administration develop a national intelligence strategy.

Don't just come every year and say, "We need this for that, and that for that, and so forth," because then you're going to get trapped, when the budgets go down, so does intelligence. You always need intelligence, but for what?

The Philippines are about to go down, and we don't have any assets in place in the Philippines because we didn't plan, and we still aren't planning, for that eventuality. But they are, and we're going to be just like Nicaragua: there was nothing in place when Nicaragua went down. Nothing in place when Teheran went down. Nothing in place in Lebanon, when Beirut and everything else went down.

Because we deal in today, and we don't deal in tomorrow.

So that's coming. Thank you for asking that question.

PARTICIPANT: With the social security system, work on the social security trust fund, how is it that -- you know, there are balloons going up all the time about cutting social security will help reduce the debt, or help the deficit problem. I don't see how that works.

SENATOR DURENBERGER: Social security, the social security system in its three parts -- OES, the disability, and Medicare -- are currently all budgeted in the so-called unified budget, which gives you a $215 billion deficit at the end of fiscal '85.

If you took social security and the three social security trust funds off of that budget, did them separately, the current deficit of everything else is 286 -- 2-8-6. So today, that $5,400 per person per year per job is generating a surplus. But also today, the social security trust fund is $7 trillion under-funded, meaning that there's $7 trillion not enough. Even as it goes up to 8,000 and 12,000, it doesn't raise enough money by $7 trillion to fund the life expectancy of all of the people that are currently in the system.

So what does that say to you? Either you're going to take it up to $20,000 a job, or $30,000 a job, or

you're going to change the nature of social security. You're going to make it a wrap-around to the other things that we subsidize by way of income security.

Now, that's the bad news, because everybody will get scared to death and say, "Oh, you can't touch social security." The good news is, we've got about 15 years to reform it, if only we will understand these things.

The demographics from now to the year 2000 give us a surplus edge in social security to work with. I'm using that right now in Medicare to reform the whole health care system, prospective payments and DRGs, and all that sort of stuff. We've already saved the Medicare trust fund from bankruptcy. Now, we're going to save it enough money so that we can put other kinds of benefits into the Medicare program, like catastrophic and preventive benefits and things that make sense, so that folks don't waste their money.

Now, if we do that same thing on social security, we've got 15 years -- if we commit today, that we want to save social security -- to change it.

PARTICIPANT: What approach would you make to both balance the budget and reduce the $2 trillion national debt?

SENATOR DURENBERGER: First, I think, as a practical matter, I have to put in place a mechanism like

we're doing today. I need something, a forcing mechanism, to force everybody to take action.

The President has to submit a balanced budget. He hasn't done that in the five years he's been in office. He has to be forced to give us a balanced budget. Then we have to be forced -- even though we disagree with priorities -- we have to be forced to submit a balanced budget.

So a constitutional amendment to balance the budget, this thing we're doing today, anything of a forcing mechanism, is number one.

Second is reform. The reform in Medicare has saved $30 billion in the first four years, and it's about to save another $11.8 billion. Turning around the incentives in the way hospitals and doctors and so forth meet the needs of people, with the help that all of you people are giving us on reforming this whole system. Reform is the way to do it.

How are you going to change social security? How are you going to deal with the defense department? Getting inside the income security system. Yes, we all think 401K is great. Is that the only thing we ought to be doing, or is it the best thing we should? What should we do, by way of qualifying borrowing against 401K, education, homes, you know? How are we going to make those decisions?

You've got to get inside this thing and turn it

around, make it make sense. The current system of spending in this country is built on a '60s model. You need to rebuild it on another model.

PARTICIPANT: If you pass a forcing mechanism this year, what says you can't un-pass it next year?

SENATOR DURENBERGER: The presence -- well, somebody says, "The sight of the gallows sharpens the mind," or something like that. The answer to your question is, even-numbered years.

Half of my state is dead, or dying. Dead, or dying. Twin cities are a gang-buster, relatively. Everybody else is -- like that. We're going to lose 15,000 farm families this year, and I don't know how many next year. That means, all these little towns are going down.

You take the assessed valuation of farms from $3,000 an acre down to $600 an acre, what happens to the school district and all the rest of those public services? The whole of rural America is going down the tubes, I mean, because all of this is happening so quickly. This sort of recycling of America, or the reindustrialization of America, is happening too quickly. Now, we could have phased through this somehow, but with deficits and high dollars, foreign import competition, we haven't had the time.

So those people are going to keep me honest, and they have focused on the deficit. They haven't focused on

tax reform, or anything else. They've focused on the deficit. So that's going to keep us honest.

PARTICIPANT: We continue to read Time Magazine and such on the famous $9,000 wrenches and $600 toilet seats. And then, I read that some companies are gypping the government and the (Inaudible) for paper and specifications (Inaudible) That, in light of deficits and tax reform -- this drives us crazy back home and out in the street. Why don't you (Inaudible)?

SENATOR DURENBERGER: Well, you can do something about the procurement process, but all you've got to do is modify it by a billion dollars here. And the reason you can't do anything about it is that I can't run it -- I mean, I can give a great speech on the subject, and I can write a great book on the subject -- called Neither Madmen Nor Messiahs, for those of you who are out there looking for the book --

(LAUGHTER)

SENATOR DURENBERGER: -- but I can't do it. And Ronald Reagan's got only eight years to do it, and he's got only three left. And they're all just, they've got their calendars down there in the Pentagon, and they're just checking them off, day-by-day, you know.

(LAUGHTER)

SENATOR DURENBERGER: Can't wait for him to get

out of there, see.

And that's -- I'm going to write a little Op-Ed piece on the fact that Barry and Sam are on the right track in trying to reform the whole system, but they aren't going to make it because they attacked the organization. And that organization will see that it outlives -- What happened when Dave Stockman said, "Why should we be paying young people at age 42, 50 or 60 thousand dollars a year to get out of the military?" What happened? Every retired general and admiral in the country strung Dave Stockman up on the gallows, immediately.

And that's going to happen to anybody who tries to change that system. It's really unfortunate that Ronald Reagan didn't, you know, the day after the election, say, "Hey, I'm going to change this whole thing, and I'm going to start with things like the retirement deal. Now that we're paying you a living wage, we don't have to pay you a pension that is going to break the back of this country."

And then say that to the civil servants, and say that to a whole lot of other people in this country. But he hasn't said it, unfortunately. That's the only way. You've got to get inside that thing and turn it around.

Eventually, it will happen. I mean, the Sam Nunns and the Gary Harts and the Bill Cohens, and a lot of those people of this world are going to be in power some

day, and that place will change. It's too bad it can't change more quickly.

MODERATOR: Senator, poor Mike Nugent is sitting back here in a dark corner wildly raising his hand.

SENATOR DURENBERGER: Oh, all right. There's a fire in the lobby, right?

(LAUGHTER)

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Yes, I'll do that very, very quickly. And -- thank you, Mike.

(LAUGHTER)

SENATOR DURENBERGER: I said something earlier about my parents having me in 1934. And I'm now on a guilt trip, as far as my kids are concerned. So Jim and I and a bunch of other people -- Don McNaughton, who is chairman of HCA, and a number of other people -- put together a national organization called "Americans for Generational Equity," AGE.

We are trying to enlist everybody's support in a positive way of making sure that my generation isn't the first to hand off to its kids a worse life or a poorer life than we were given. That's it. And to try to do it in a very positive way, so we don't be "granny-bashers," and all that sort of thing, and don't scare the hell out of my folks, while we're doing it.

But we have become convinced that this message of generational equity: How is it that I can leave my children at least as well off as I was, given the fact that my parents have left me so well off? And I'm about to break those kids. How can we do that as a nation?

So what we're trying to do is to get you and everybody in this country to think positively about social security reform, about defense reform, about balancing the budget. How do you put the younger people in this context?

That's what Americans for Generational Equity is all about. Hopefully, you'll all sooner or later get little letters asking you to become a $5 a year member, or something like that. It'll be a -- in the beginning, we need to raise some corporate money, just so we can do our mailings. Then, it's going to be strictly a membership organization.

If you believe in leaving your children at least as well off, we'd like you to belong to the organization. Mainly, what you'll get is information. We won't be lobbying, or beating up on old folks, or anything like that. It will be largely information that you can then use in dealing with your own parents or your kids, or whatever.

(END OF RECORDING)

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Health Care Expectations in

the 99th Congress

Senator D. Durenberger & Congressman F.H. Stark

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PROCEEDINGS

VOICE: Welcome to the continuation of the 1986 Annual Conference of American Nurse Anesthetists, Washington, D.C. This is the closing general session, tape 106. The topic is Health Care Expectations, the 99th Congress. The presenters are Senator Dave Durenberger and Congressman Fortney H. (Pete) Stark.

Thank you. This is tape A.

VOICE: I'd like to introduce the senior Senator from Minnesota, who is also Chairman of the Health Subcommittee of the Senate's Finance Committee, and his focus is on increased efficiency, competition and consumer choice to improve the nation's health care. Senator Durenberger is going to come and speak to us this morning on health care expectations of the 99th Congress.

Senator Durenberger.

(Applause.)

SENATOR DURENBERGER: Good morning. Thank you very much. Thank you very much. Did the Minnesotans get in the room?

(Laughter.)

Great.

I'm just proud of the fact that about a third of you are from Minnesota. At least that's what it looked like in the room over here.

I want to say to the rest of you, who aren't lucky enough to be from Minnesota, this is Minnesota weather here you're enjoying right now without the mosquitos, which is our state bird.

(Laughter.)

For the rest of you, I want you to know that 24 hours a day, 365 days out of the year, your counterparts in Minnesota are lobbying me, so --

(Laughter.)

(Applause.)

So when we get to the part where I say S.1154 is going to become law I want you to give them credit for it.

(Laughter.)

(Applause.)

Usually when I get up here, even early in the morning, somebody will give a long, belabored introduction and I'm glad that didn't happen. I am very grateful for that.

But the one nice thing about it is that in order to give some dimension to who Dave Durenberger is, other than a four syllable last name and he's not running for president and stuff like that, usually the introduction will say I'm a member of the Senator Finance Committee and Chairman of the Health Subcommittee and I'm a member of Governmental Affairs and I'm Chairman of Intergovernmental

Relations and I'm on the Environment and Public Works Committee where I'm Chairman of the Environmental Oversight and Toxic Waste Subcommittee, and I'm also currently Chairman of the Senate Intelligence Committee. That gives me the opportunity to find out how many people in the room know what an oxymoron is.

(Laughter.)

Two words that are mutually inconsistent, such as honest politician --

(Laughter.)

-- or Senate Intelligence --

(Laughter.)

-- and then I always say that in the previous Congress, the 98th Congress, I was also on Senate Ethics, and --

(Laughter.)

We have to stop knocking ourselves because this, too, is a noble profession. Twenty-four hours a day and three-hundred and sixty-five days a year we are in public service, and we're not paid as well as we ought to, which is true of the nursing profession. We have the same compassion, even though it doesn't look like it. But the one big difference is that you work very hard almost for nothing to hang on and promote your profession, where we have political action committees and we have all that sort

of thing to keep us in even numbered years recycled through this process.

So what I'd like to talk to you about today is, very briefly, where the world is at, as viewed from Minnesota and from Washington at the same time, where health care is in that, and then what I think people like Dave Durenberger, Pete Stark and others need your help to do something about it.

First, yesterday, on a similar time, I was on a panel on tax reform and somebody wanted to know what's going on -- what is this tax reform we are up to. I said, well, it all started in 1977 in California -- or 1976. Yesterday was the tenth anniversary of the introduction of Proposition 13 in California. Proposition 13 is still in effect. It is an effort on your part to say to me that the only way you're going to get me to change my spending is not to give me any money.

Now, the view from Minnesota of Washington is that Washington is the problem, not Minnesota, and that if you give Washington less money to spend in the form of taxes they'll have to change the way they spend the money they are now spending, get more efficiency into it or do something like that, and then everything is going to be better in this country.

But the problem is the inefficient use of public

money. We're spending too much money on too many -- frittering it away on too many things. We're getting involved in too much. We're all this sort of thing. You all know the line because you write to your own Congressman and Senators with great regularity on these subjects and then you throw them out of office. In 1978 and 80 you threw out a bunch of Democrats; you put in Republicans.

Have things changed? Have things changed? Well, yes, they have changed. But you still won't pay your taxes because the view is that we still haven't changed the way we ought to be spending money. And that view is exacerbated by the fact that the difference at the national level between what we spend and what we take in in taxes is today in total, since the beginning of our history, $2.336 trillion. That the current difference, in the year 1986, between what we spend and what we take in from the people of this country to pay for what we give back in various public services is $230 billion.

In 1987 the federal budget will be $982-3-4-5 billion dollars, depending on whether or not we do an adequate job of prospective payment and DRG reimbursement. Twenty percent of that will be debt service. Twenty percent of that will be interest on the national debt. $196 billion in the fiscal 1987 budget is to pay interest on the national debt.

Now, having said all that, the next thing a politician is supposed to do is distance himself from the Congress. Hey, since there's only one of me here today, I am the good guy and all the rest of the folks up there on the Hill are the bad guys. And the reality is that every year you come to Washington and every conference and every time one of your politicians come home to whatever state you're from they do exactly that.

I had to have a joke once when I went to Texas, and it's really hard to think of good Texas jokes, so --

(Laughter.)

So somebody gave me this little riddle. It said, ask them when you get there why there were so many heros at the Alamo. I said, why were there so many heros at the Alamo. The answer is, because there was no back door.

(Laughter.)

(Applause.)

Even in Texas they laughed at that because they know in the Alamo that was Davey Crockett and guys from Tennessee.

(Laughter.)

But, think about that.

I got to thinking about that afterwards, after I told the joke, and I put it in the context of the rest of the things I talked about, which was the budget and the

deficit and all that sort of thing. And I said, you know, Congress in Washington is just like the folks in the Alamo, and ever since Proposition 13 and all that sort of thing, the folks in the Alamo have been trying to figure out how to bust out of this thing and respond to the public's desire to get more for their money.

Now, the difference between the Congress as the Alamo and the real Alamo is that there is a back door and it opens up in even numbered years and we all walk out, one at a time, to our constituents and we say, I have a plan to balance the budget. I have a plan for tax reform. I have a plan to do this, that and the other thing. My problem is the folks back at the Alamo.

Think about the newsletters that your Congressmen have been writing to you over the years. We all have done the same thing for 15 to 20 years. We have made ourselves individual entrepreneurs at the expense of a larger corporate endeavor. Every one of us knocks the Congress. Every one. I've only been here since 1979, but I was told when I came here that's the way to survive.

A famous Senator from Wisconsin, who is no longer here, said, Dave, when you get up in the morning look yourself in the mirror and picture underneath what you see in the mirror one of these buck-stops-here signs. You know, like Harry Truman had on his desk. Only your sign says, the

buck does not stop here. He told me that. That's the reality in the Congress.

Now, that's what we're suffering from. That's what we're suffering from. I think we're suffering from two things. One, we all want to be individual entrepreneurs rather than part of a larger corporate endeavor, and, two, we're just like you. We want to blame somebody else for the problems. Now that I've gotten you involved in this, hopefully -- I don't want to make you mad -- but the reality is when the folks in Minnesota sent me to Washington to balance the federal budget they were sending somebody who'd never balanced his own budget in his life.

(Laughter.)

I'd hate to ask for a show of hands here of all the folks that are living within their means in this audience. You haven't been taught to do that. You remember your folks telling you that that's what you ought to do because that's what they did. But my generation has never lived within its means, and why? My folks had me in 1934, the middle of the Depression. I was all they could afford to have, literally. Some of you are my age and you know it. That's all they could afford to have in those days was kids.

And when my parents' generation came to political power after the second world war they swore I would never have to live through what they lived through: sudden loss

of home, sudden loss of job. Everything tumbled. And how did they make sure when they came to political power in the Fifties and the Sixties, how did they make sure that I would never have to live through that? They created having without paying for it.

In 1959 I was able to buy my first home. I was one of the first beneficiaries of the free housing in America. I paid $500 down on mine, but if I were a vet or in other words qualified for FHA I could buy it for nothing down in the late Fifties and the Sixties. Nothing down. So I bought myself a beautiful three bedroom rambler with a rec room in the basement and a fire -- two fireplaces. We always have to have two in Minnesota to keep the place warm any time other than the Fourth of July.

(Laughter.)

Beautiful house. My dream. My dream. Available to everyone in America. $500 down. I paid $12,500 for it. In three years I sold that for $20,000 and reinvested it in a $25,000 home. But I only reinvested the $500. The rest I put someplace else.

Today, maybe I'm not the average American because maybe I've been a little more mobile. But I have converted that $500 into a home out in McLean, Virginia, where my family is, which is probably about $300,000 or $350,000. I only paid $175,000 for it when I got here, but now it's

worth $350,000. And I have a condominium in Minneapolis that's worth $65,000. I did that all off of $500 by recycling it and inflation. $500 down, turn it over after three years, pocket the extra money, invest it in something, educate your kids on it, whatever. But my generation has been able to take the average cost of housing in America from $5,000 to $86,000 in a 20-year period of time, and we have priced our children out of housing.

I've got a wonderful savings account. I can educate my kids on my home. I've got my own social security system built into my -- into this housing. When you look at my net worth you're not going to find a whole heck of a lot other than this housing. But you're going to see a guy who is a half a millionaire, or something like that. Off of a $500 investment.

My generation did the same thing in health care. It said the place to buy insurance protection for your health is when you go to work. The government is going to give all of the employers of workers a tax deduction for buying health insurance and it's not going to require the employees to report the value of that health insurance as income. That was in 1954. Twenty years later most of American workers had almost fully paid health insurance, but that's not the heart of the problem. That's just the cause of the problem.

When I went to work, every place I went to work they gave me something like this and they said this is your Aetna, Blue Cross. I mean, you name it. Fine print, never looked at it. Stuck it in ~~a drawer some~~place, and when I got sick I went to the doctor or the hospital. When I got the bill I sent it to the insurance company.

So, ladies and gentlemen, as a result -- I won't give you all the statistics about $500 a day to go to a hospital, but you know the result. My generation is the first to believe that it has a right to smoke itself to the edge of death and be pulled back by an artificial heart.

(Laughter.)

(Applause.)

My generation has been raised to believe that it is easier to get sick than it is to stay healthy. Look at these beautiful people in this room that take care of you when you're sick. You go to the hospital and you have all this wonderful, loving, tender loving care and the folks from work who are dumb enough to stay healthy come to see you --

(Laughter.)

-- and they shower you with flowers and cards and -- I mean, we made Hallmark an institution --

(Laughter.)

-- with this piece of paper, free health

insurance.

It's amazing that people jog and eat the right kinds of food and things like that because there is no rewards or incentives, other than the ones you create for yourself. Buy and insurance policy today and see if there is a lifestyle difference in insurance. Of course not.

I don't want to belabor the point, except to say this, that as we come to Washington and we talk about making health policy and we talk about getting the politicians to live within their means and we talk about getting more for our health care dollar and so forth, remember the we. The politicians didn't create this system. You and I did. You and I created this system. We have all insisted on having without paying for it.

And now we have a situation where whether it's housing or health care or -- this incredibly poignant movie, television. The CBS special that Bill Moyers did a few months ago. Hopefully it's going to get replayed more. These poor black kids are trapped in this ghetto in Newark, New Jersey. How many of you saw this? It was a Saturday night. I sat there on a Saturday night and cried watching this movie. These teenage kids walking around with their boxes, you know, talking for an hour and half about playing mommy and playing daddy without any responsibility to the consequences.

So this comes full circle. The old values that my parents had and that they left me with up here were the values of living within my means and taking responsibility for my actions. But, oh, is that hard to do. Is that hard to do today because everything in my generation has spoken against living within my means. Has spoken against taking responsibility for my actions. And those kids in Newark could have been white or Oriental or East Asian or you name it. It was not an ethnic film. It was a generational film.

That's what's at the heart of changing the role of government and the lives of people, is changing our appreciation for the values that our parents tried to deliver to us and it's hard to do.

Now, those of us in the health profession, you're delivering 24-hours a day, 365 days a year -- in the leap year you get an extra day to become passionate -- and us in Washington, I can't -- I have trouble pronouncing, you know, the words that go with CRNA. I have trouble with all these diseases. I'm not very smart at the kinds of things that you can do so well and so automatically because it just comes from the heart.

But I'm at the other end of the spectrum and I'm trying to deal with the reality of why you went into the profession. I really am. And so are you.

(Laughter.)

So I came up with an idea. Not just me, several other people. Currently the policy changes that are going on are called consumer choice in health care. I have encapsulated some of these ideas in my first -- really my second book. It's the first one on health care. There's another one in the works. This book is called Prescription for Change. I don't know where it's available, except in my office, but --

(Laughter.)

Consumer choice. Consumer choice.

If I don't play any role in deciding whether I am going to stay healthy or get sick, if I don't play any role in financing the choice of protection if I get sick -- and I'm going to get sick -- and we're going to have $196 billion deficit or a $196 billion in debt service and a $2.336 trillion debt and we're going to have kids jiving around with their boxes saying I got no responsibilities.

But, if you have a choice and if you know you have to live with that choice and if in making that choice you have at adequate information and sufficient financial resources to make a choice, then we can balance budgets, we can live within our means and we can have a society in which we don't need to fear those who don't take responsibility for their actions. That's what we're up to in consumer choice and health. We're changing the way we finance the

delivery of health care.

We're putting a price on a whole lot of things, and why are we putting a price on a whole lot of things? So that the best people will get the business. So that you don't determine which person takes care of me on the basis of the license that's hanging on the wall which over the last 25 years has largely been put up there for economic reasons, but on the basis of the person that can provide me the best possible care.

And that why in your profession you have -- and nursing generally has everything to gain from consumer choice in health care because you will break down a system in which whether it's economically motivated or whatever -- I don't want to be critical of the power that has existed in the medical provider profession of the past. The reality is the best people ought to be able to care for the most of us.

And so as we go through prospective pricing and we go through DRG's and all of those sort of things, that's where we are headed. That's where we're headed. And it's hard to take a transition at any one point in time and for you to know exactly how we're going to get where we want to go. I can describe it in various ways.

Sometimes, if I have time to think of it ahead of time, I pull out my plastic card and I say the ultimate in America -- people talk about national health insurance and

now that Kennedy and Durenberger are showing up on more bills again all my conservative friends in Minnesota think I've gone wacky. I've bought into national health insurance or something like that. And the reality is, I suppose, that conservatives and liberals in this area are meeting somewhere in the middle, but --

One of the things that I think Teddy and I both understand is that we've had national health insurance in America for a long, long time, and they're called the doctor or the hospital, the nurse, whatever. If you're asked to care for somebody -- you come across somebody -- an automobile accident out in the middle of the highway and you have any background in delivering health or medical services you leap out of your car and you rush over there and you make an instant determination as to whether or not you can be of help and you do it. You don't ask anybody to pull out their plastic card or anything like that. You take care of them. And in America we built hospitals across this country to do the very same thing. You're sick, you walk in the front door and you come out repaired in the back door.

We have a national health insurance -- have had a national health insurance system in this country that did just that. Places we could go, people to whom we could go and they took care of us and then they asked questions afterwards, and you wonder how did the hospital, for

example, finance all of this. Well, you know how they financed it. The people who could pay paid a little extra so the people who couldn't pay could be taken care of. That's how it worked.

We did the same thing with medical education. The people who had insurance policies when they came into the hospital paid for medical education in America. That's how we paid for research. Same way. This is the national health insurance system. But when it gets to be $500 a day to get into the hospital and when insurance premiums that are paid for by companies go up 25 percent a year, all of a sudden the payers say I only want to pay for what I get. I don't want to pay for medical education. I don't want to pay for the poor. I want to pay to have my appendix out, period.

And now that's what we're up to. Now that's what we're up to. Redefine what we mean by a commitment to national health insurance. Some people say we shouldn't say national health insurance. We shouldn't guarantee every American access to health care. I say, baloney. What do you have a society for unless it can guarantee to everyone access to a certain basic set of human services.

How are you going to do it. The ultimate is ten years from now everybody in American will have a plastic card. Maybe it won't be plastic. Maybe it'll be gold or

something. I don't know. Maybe they'll just have a number and punch it into a computer. I don't know. But let's say a plastic card because that's what we are using today. Everybody will have one.

And what does it represent? It represents a choice that people make annually today from a set of choices of health plans. The health plans are the buyers of health care services. I don't know who the health plans will be ten years from now. It's in transition. It used to be insurance companies. Today it's some combination of insurance companies and the Blues and HMO's, PPO's, IPA's. But they're doing the buying, and every year I've got a choice in my job -- the Federal Employees Health Benefit Plan, I've got a choice of 22 plans. That's too many. But at least I've got a choice. There's my plastic card.

Now the elderly are moving in the same direction through competitive medical plans. Same choices for Medicare. What the government will do through Medicare is pay to the health plan a dollar denominated premium based on age, sex, previous health condition and the average community cost of health care.

The poor, the same way. Through Medicaid or some other program. Same thing. Help them buy insurance.

So when the people come into the hospital or the doctors office, the ambulatory surgery center, they've got a

plastic card. You can't tell whether they're indigent, Medicare eligible or work for the federal government or Exxon. That's where we're headed.

The question is how best to finance it and we are in the process now of making those determinations. Moving through a system of prospectively pricing these services. The danger will be losing quality because in the near term those of you who have experienced fighting, as some people say, with HMO's say, hey, they're skimping on quality. In a lot of places that's true right now.

But in the end -- in the end, the American consumer is only going to buy quality or value, which has a quality measurement to it, and how we get there is largely up to all of you. You have to do what you're now doing. You have to make sure that moving in the direction of consumer choice and prospective pricing is done correctly. Your support for my efforts to find a better way to do the physician reimbursement has been very meaningful to me because the radiologists and the anesthesiologists and the pathologists have dumped on me, and I want to prospectively price what goes on in the surgery suit because all the data says there's very little variation in there.

So I would like to prospectively price that. But you're the only people that have been supporting me. So keep it up. I'll try not to get too discouraged. And in

return -- and even though we were limited by the Byrd Amendment in the Senate not to be able to do anything about Sparky's bill, in return, when we get the conference for the House and reconciliation which we all hope to God that we do, I'm going to grab the opportunity to reimburse on the payment system the CRNA's.

(Applause.)

Thank you. Thank you very much.

I've talked too long and I want to leave you with -- that would be a great place to sit down, but --

(Laughter.)

I can't help but putting a plug for an organization which I helped start called American for Generational Equity and I can't think of a better place to do it because if there's anybody that sees families in pain, it's you.

A couple, three years ago a fellow who worked for me came to me and said, Senator, do you know that this year -- I think it was 1983 -- the money that you borrowed to run the federal government, which was then $140 or 50 billion, I am going to have to pay back -- for every $1.00 you borrowed, I'm going to have to pay back $28. That started Americans for Generational Equity. That an a concern I have for my own sons and what -- I priced them out of housing, I'm pricing them out of health care, I'm -- you know, all

this sort of thing. They're going to pay $6,000 a year now in social security system and it's not going to be there for them. All of these things.

So, a bunch of us have started an organization called Americans for Generational Equity. We've not trying to pit the young against the old. We're trying to tell the story that I tried to share with you here this morning about how we got into this, all very well intentioned. But now we're in it and we have to get out of it, and we don't get out of it by cutting Medicare, by cutting social security. We don't get out of it by beating up on my parents.

We get out of it by zeroing on the number one problem, which is about the 50-year-old who has got 15 years left to change the Tax Code and do some other things that make some sense in America. So, as you read articles -- like in U.S. News last week about generational equity -- don't think of it in terms of conflict. It's not the young kids against the grandparents. It's my generation and what it needs to do in the 15 or 20 years that lie ahead of us to restore a sense of value, taking responsibility for our actions.

Thank you very much.

(Applause.)

VOICE: We'll go ahead and take a coffee break at this time. Coffee should be outside the back door, as it

was on Saturday.

VOICE: Good morning. I would like to begin the second half of our morning session.

First I would like to make an announcement. There will be boxes at the registration desk to collect your CE records and please leave them there when you leave the meeting.

I am happy to present Congressman Fortney Stark. He has represented the Ninth District of California in the U.S. House of Representatives since 1973. In the 99th Congress he is Chairman of the Health Subcommittee on the House, Ways and Means. He has been an outspoken critic of Medicare policies which discriminate against beneficiaries and are not cost effective. He has also been a supporter of favorable legislation for CRNA's.

(Applause.)

I am very happy to present to you Congressman Stark.

(Applause.)

CONGRESSMAN STARK: Catharine, thank you very much, and I apologize for being late. I would point out to you that Dr. Byron Biles -- Brian Biles who -- you're lucky I don't answer quorum calls. It was like a bad attendance record in junior high school that's got me into that.

We have been -- Dr. Biles, I'm sorry, is the

Chief of our Ways and Means Committee Health Subcommittee staff and comes to us from the -- originally from Senator Kennedy's staff by way of Congressman Waxman's staff by way of being Assistant Medical Director, most recently, of the State of Maryland, and we're very excited to have him helping us work on legislation which affects primarily 30 million beneficiaries of the Medicare system.

I thought I ought to explain to you that I do have some problems. Aside from the obvious physical limitations under which I operate, it's been brought to my attention recently by the American Medical Association that I have severe personality disorders.

(Laughter.)

I have been told that I am arrogant and inaccessible. As far as the arrogance, we have made an offer to Don Rickles to come on our staff and do sensitivity training.

(Laughter.)

And also as far as being accessible, Dr. Ruth is going to come and deal with that.

(Laughter.)

And because I have often criticized the AMA with only being interested in getting paid and they keep arguing about quality, we are going to have a Claus von Bulow award for medical ethics.

(Laughter.)

(Applause.)

I guess the bad news is that the AMA wants to spend $250,000 to aid my opponent in California and $250,000 for one of the sweetest human beings alive, Andy Jacobs from Indianapolis who used to Chair the Health Subcommittee, and I guess that's the bad news. The good news is they've hired a neurosurgeon to run the campaign.

(Laughter.)

(Applause.)

And now that we're all awake let me just very briefly -- aside from the obvious handicaps under which I operate, let me tell you a little bit about how I feel about your profession and health and medical care in general, which perhaps will let you understand my arrogance and certainly my lack of expertise in the field in which you are all professionally so well equipped to deal.

Health for me is not a medical problem and I don't deal in the health field. My definition is that health is, if you got up this morning, which is a pretty nice sunny day for Washington, and you look forward to what you are going to do today and your sex life was all right yesterday and you feel pretty good, you're healthy. And if you hurt, if you sprained your ankle or you have a hangover or some other part -- moving part isn't functioning properly

you need medical care.

And I make that definition because I think health is part of -- is such a broad issue. It's an environmental issue. It has to do with our communities and how we live and how we raise our children and a whole host of things which I think are beyond the scope of those of us who are trying to deal with the I hurt problems for American people, and I think that's important to distinguish because so often we are called on -- and when I say we or I, I speak of the Ways and Means Subcommittee on Health which basically just deals with Medicare and to a large extent deals just with Part A, although there is some interconnection, and that's a limited amount. Admittedly, it affects a lot of people.

But I am getting people coming to me saying we really want you to deal with long term care and what they really mean are nursing homes or custodial care. That's a very expensive proposition and I don't think America is ready to face that unless they're ready to face some of the financial responsibilities that the families bear toward their parents or toward other -- or toward people who are disabled, in addition, and it certainly was never intended nor could we afford to care for it in the Medicare system as it is presently constituted.

And I don't mean to turn my back on that problem or seem to be aloof from it. But it is not a part of the

Part A system of medicare which needs a lot of help all by itself, and so I tend to want to rifle shot, if you will, the problems that our Subcommittee faces and that I would like to address.

I often hear, and I do hear from you all on occasion on the issue of quality and I -- the cloakroom intimidates me. The quality issue, thank you, is one which I don't' want to turn my back on, but one which I don't think I should resolve. That's up to your professional associations and your licensing bureaus and, if no one else, the district attorney in your home county. My theory is that if the Hippocratic oath doesn't do the job, a short of long vacation at government expense will and we'd probably get a little jail reform tossed in if we had stricter laws.

I just don't think that when a lay person is purchasing medical services -- there is never a question in my mind that we are going to have second class quality. I am perfectly willing to negotiate with you and your professional associations, as I would be actually with the AMA, if we just got it right out front. If it's a matter of economics and how much you ought to be paid, I can deal with that. As a matter of fact, I can appreciate it and I can suggest to you that I'd like to be fair. I think I can be tough, because, on the other hand, if I don't -- in addition to representing 30 million beneficiaries for whom I want to

get the best services I can get, I also represent a couple of hundred million taxpayers and they're going to turn me out if I don't buy the services from you at the best cost I can get.

And I would be embarrassed, quite frankly, if Joe Califano, who used to be on my side, buys it -- buys services any less expensively for his Chrysler beneficiaries than I can get it for Medicare beneficiaries. I'm proud of our record. I think we paid and offered to pay fairly and I think we've gotten some good bargains for our beneficiaries and we'd like to continue to do that.

I like negotiating with you and I hope I can do that with PROPAC and FISPAC and your organization and all the other people from whom we procure professional services and/or equipment and other medical care providers. So that I look forward to dealing with you on that basis and I think our committee will get better at it and I think that the net result is we will get more and better medical services for our beneficiaries.

What do I see in the long run? I would like to have a relatively short tenure as the Chair of this Committee. I came to it, as many of you know, by accident a little -- almost two years ago when there was a reorganization in the Ways and Means Committee where I had resided in the committee that did technical tax provisions,

which I always thought as a banker I knew more about beating the Tax Code than most people and I was doing a relatively good job there.

I woke up one Tuesday morning, went to a meeting, came out of the meeting by noon and found I was Chair of the Health Subcommittee. Imagine going to bed at night thinking Jim Jones is going to head the Health Subcommittee and waking up in the morning and finding you had me. That may have been what started the downward spire with the AMA.

But I did find -- that was Tuesday. By Friday I found six organs in my body which I didn't know had existed --

(Laughter.)

-- and each one had a lobbyist here in Washington and HUMANA sent me a letter offering to transplant any one of them, either plastic or used --

(Laughter.)

(Applause.)

-- and I was in the Medicare business.

What I would like to do, and it's really very simple. I would like to end the gaps in Medicare. There is only so far that we can go in providing benefits to our beneficiaries and you're all aware of the first day co-payments and the gap in the -- what is it, 60th to 90th day and a limitation to number of days. I think it's fairly

clear. You've all seen all these handsome, kindly, sincere looking people on television who will tell you for only a few bucks a month you can forestall the danger of having to pay $18,000 bucks that the government doesn't pay in Medicare coverage.

That really is a ripoff by the insurance companies and the federal government could close those gaps. We could have eliminated them in Part A in our bill this year and guaranteed that no one would be more than $1,500 out of pocket in any year for complete Part A coverage. No co-pay, no limits on days, some limits still on skilled nursing facilities at the end and merely by having state and local employees who do not now pay Medicare, 90 percent of whom eventually end up getting the benefits anyway, but just those who do not now pay their Medicare one and forty-five hundredths percent. If they paid, we could increase the benefits to all beneficiaries to say that no one would have to come out of pocket more than $1,500 a year. That isn't bad. And I'm not sure we'll ever get it down, say, much below $1,000 and those who can't afford $1,000 will have to be picked up by Medicaid or other systems for impoverished people. But that's what I'd like to do.

Medicare could go just so far and then it's merely a question of fine tuning and what services will include, and that is something that probably you'd be

happier having somebody with more expertise than I have. But I really am committed to seeing if we can take that fear -- my mother still has eight Medigap policies. I said, mother, you know, look, I know about this now. I'm running it, mom --

(Laughter.)

-- and I said, you don't need them. She said, son, your dad bought those policies before he died. I'll sleep on a grate. I'll embarrass you. I am not giving up my Medigap policies.

I guess I'd like to take that fear out of our clients, the senior citizens, and turn it -- make the system provide truly comprehensive Part A coverage and I -- that may take us a couple of years -- it may take us a little longer -- and along the way perhaps put you and your fees under a DRG system. I know some of you may have some disagreements about that, but as I look at it it would give us a chance to let you bargain more effectively with the providers and give us some continuity of cost and be better able to adjust costs across the country, which is again something that is a mystery to me.

I have trouble deciding how medical costs for a procedure can be 100 percent different as between, say, New Haven and Boston. I think both are uncomfortable places to live in the winter. Both have excellent medical schools.

Both -- I don't know, is there any great cultural difference between the two cities, and I apologize to the residents of those two cities who may disagree. Both have Shubert Theaters, or did.

I can't understand for the life of me, particularly if you take wages out of the equation, why an appendectomy, if that's what it is, would cost two times as much in one city as the other. That makes no sense to me and as soon as the difference gets to be the equivalent of a round-trip ticket on the shuttle it seems to me we just close down whichever is the highest cost and start buying airline tickets, particular for elected procedures. But that may be simplistic in its approach, but it is the sort of thing that still puzzles us.

So, I look forward to working with all of you in these next several years to expand the services and expand the ability for us to provide the ever increasing kinds of medical care that the public is discovering, to deal with the ever increasing health needs of this country as they can be solved by the medical care delivery profession.

You've been helpful to me. Your lobbyists here in Washington have been absolutely excellent and they have dealt with us in the area of providing information to us when we need it, providing understanding when we cannot provide 100 percent of all of your legislative objectives

realizing that we are dealing with an Administration who is constantly trying to reduce the costs. I've always categorized it. It started with David Stockman, but James Miller who is now head of the Office of Management and Budget has taken it to an art form and it's amazing to me how this Administration can know the cost of everything and the value of nothing.

It is a very frustrating and dispiriting experience to have to provide what we all know is a necessity and to find that we're constantly doing it by saying if you cut the cost somehow you all will find a way to work harder and longer for less money. That just isn't fair.

I want to thank you for having me here with you this morning. I'd like to stay as long as I can and answer questions and get you -- give you a chance to shoot back, and I know that many of you have more detailed questions you'd like to ask so I'll just look around and see who wants to fire the first shot.

She's either running out or running for the microphone.

(Laughter.)

MS. ALSHAVER: Representative Stark, this is Gail Alshaver from the State of California.

I, too, like yourself cannot understand why the

cost of a procedure is vastly different from one location to the other, and in keeping in tune with this, I cannot understand why we have current proposals on Capitol Hill that would decrease the DRG reimbursement to rural hospitals. I wonder if you could respond to that.

CONGRESSMAN STARK: I don't know as we're decreasing the DRG's. I think we are probably not increasing them. Is that -- for rural. She's saying for all hospitals. Yeah, I think in our bill we have a 1.3 percent increase for all hospitals and I don't know as we've singled out rural hospitals for any particular decrease.

Am I missing something?

MS ALSHAVER: There is something -- some type of proposal, and I'm sorry I don't have the number right off my head. I know that I did respond in letter from in reference to this because I cannot address that the cost of delivery of health care in a rural situation is any less than in the metropolitan area.

CONGRESSMAN STARK: There has been some question about bed sharing -- swing beds in rural hospitals, perhaps, and there's also been some question about providing for higher cost DRG's in rural hospitals, but I don't think in California, unless up in Susanville or someplace that I'm missing -- and I don't mean to suggest that it isn't important to have a hospital in Susanville -- that we have

done anything specifically targeted at rural hospitals, particularly where they are a sole provider in a community. I think there we've been overly generous.

I, for one, don't feel that because a person is a rural resident they should suffer from lack of facilities. I might suggest that we have sometimes gone a little overboard in providing high capital costs. I'm not sure that every town of 500 needs a CAT scanner, if there's one available within a comfortable drive. But other than that, I don't see why rural hospitals should suffer.

MS. KATCHPOL: I'm Maddie Lou Katchpol from Springfield, Illinois.

I thought I heard you say that you were contemplating putting your expenses, meaning us, of course, under DRG's. Should I also have understood that you meant to put all anesthesia care providers under DRG's?

CONGRESSMAN STARK: Yes.

MS. KATCHPOL: Good. I'm glad to hear that.

CONGRESSMAN STARK: And as a matter of fact, I -- I guess the head of the radiologists, who testified before our Subcommittee, at least paid me a grudging compliment in that while I didn't agree with him or their position, that we listened attentively and tried to understand their problems.

It's my present feeling that we would be better

served in Medicare to put what I refer to as the RAPS -- and I gather you all know what that means -- under a DRG-type reimbursement system, and I could argue that at some length. And if in fact we are successful in doing that, that you all should be reimbursed on the same method and then you, I think, would be better able to compete in providing services.

I am always hesitant to tell other folks what's good for them. But I do feel for the Medicare system we would be better served if we were purchasing those services and my clients, if you will, the senior citizens, who I think are getting overcharges in that area, and I have yet to run into the senior citizen who bargained for any of their RAP services directly, or even knew perhaps that somebody else was bargaining for them.

So the charge that a patient ought to be able to select his or her own services from those people falls on relatively skeptical ears, as far as I am concerned. But that is one of the reasons that I'm suggesting postponing.

The fee for service payment that some of you would like to have puts my clients in a 20 percent co-pay position which they wouldn't be under DRG's and also I think makes it more difficult for me to get the rest of the folks in under the umbrella, and that's sort of our strategy at this point.

Yes, sir.

MR. BEAR: Thank you. Ron Bear from North Dakota.

When is Congress going to address the major disparity in Medicare reimbursement between free-standing ambulatory surgery centers and hospital-based ambulatory surgery centers?

CONGRESSMAN STARK: Well, we are attempting to do that in -- as best we can. The ophthalmologists I think have been trying to bomb my car for this past year or so.

(Laughter.)

The disparity there in charges in lens transplant procedures has been amazing and it's difficult for us to kind of as procedures change -- what I've often said is we are not getting the benefit -- we being Medicare -- of the -- of your productivity gains. Now, I'm willing to deal with some kind of a procedure that costs $100,000 the first time it's done, but when it gets to the point where everybody licensed in that subspecialty can do it very quickly. I'd expect the cost of that procedure to come down for our beneficiaries, and when you can indeed safely and professionally adequately provide a procedure in an outpatient or ambulatory setting, I think that's fine.

I think it's probably wrong for us to pay the same amount for that as we would in an in-patient facility

because I suspect that it's a lot more profitable to do it and less costly in the ambulatory. I hate to see people taking really sick people out of an in-patient situation because of the way I pay for it. So I'm pushing as quick as we can.

I would rather, quite frankly, the Congress didn't have to make those decisions. I'm the last guy -- I don't even like to go into hospitals. You know, I'm scared. I cry every time I see somebody walk into a hospital.

I think we should have much more technically competent people than Members of Congress trying to decide how we should pay for a variety of services. Now, often it comes to us because we're there and we're political. But I see groups like PROPAC and hopefully FISPAC and HICFA, if it were working for people, as the people who ought to do that. I mean, we ought to have oversight if it gets way out of whack, but I don't think we have to do it every year, going down and deciding how many dollars and hour somebody gets for a procedure which I can't even pronounce. That it's good for you and it certainly I don't think is good for the American people.

Yes, ma'am.

VOICE: You mentioned something about the RAPS coming under Part A. Do you anticipate -- I'm sorry. I'm Chris Ambricky from Michigan.

CONGRESSMAN STARK: Hi.

MS. AMBRICKY: Do you anticipate the movement of the hospital-based physician under Part A reimbursement prior to the expiration of the passthrough?

CONGRESSMAN STARK: Which expires when? We've bumped it to 1988, October of 1988. Yeah, I think we might. I mean, it's -- I hate to speculate. Congress moves so slowly and we are jammed up now on getting our reconciliation bill through which I thought we would -- we rushed like Billy be damned to get it done just a couple of weeks ago, when I was anticipating doing reconciliation in September. So we rushed through more quickly than I thought we should have. I don't think we got as much doing it and now we're waiting and it looks like we won't come back and settle it until September after all.

So I hate to predict time tables. But obviously the longer we wait, the longer the RAPS lobbies will organize to fight against us and I -- it's hard for me to predict. We'll keep pushing and I -- it's no secret. I would like to see many more of the physician services under some kind of a DRG formula, particularly in-patient procedures. Again, that's a little easier for me to deal with and I think to the extent we can develop some severity indexes and things like that we would be better served.

I wish I could say that with a certainly and

pound the table and have a lot of zealous fervor when I say it because I'm not that sure, and I'm -- I tend to tiptoe into that minefield very softly.

(Whereupon, the speakers concluded.)

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VOICE: -- at St. John's University and has a law degree from the University of Minnesota. He was in the Army and has been a practicing attorney. He is an effective Senator. He was (inaudible) of the late '60s, and currently sits on several key Senate Committees, including Government, Environment, and Public Works, Finance, which is of primary importance to us, Governmental Affairs, and he is the Chairman of the Senate Select Committee on Intelligence.

Senator, we are delighted to have you here.

(Applause.)

SENATOR DURENBERGER: I appreciate the opportunity. Today Bill Casey called, and we each had lunch on the telephone over an article in the New York Times this morning which Bill had actually instituted, and didn't tell me until I picked up the paper and read it. So I did grab a bite to eat. I thought I would come down and share a couple of thoughts with you, including some of the work that Bill, in particular, and some of the rest of us who have been associated with him, and perhaps on a little bit of a larger context, so that you can understand why it is somewhat inappropriate to legislate as they have indicated on some of these issues.

One piece of legislation that Bill and I have

been thinking about that is relative but not mandatory is an encouragement to the President to (inaudible) a trade bill, which we might probably not have, to encourage the President of the United States, or require the President of the United States, to negotiate with the leaders of the Big Ten countries (inaudible) convene a trade desk summit which would be required to be held annually for each of the first three years around an (inaudible) trade conference.

To give you an indication, the fact that few of us here have a preference for legislating solutions to these problems. None of us like the notion that they are only talked about. The presumption is that while we are in the middle of discussing the matter, it might be a good time to require a predictable meeting of the leaders of the Big Ten nations to deal with the relationship between trade and deficit problems.

I am glad they have preceded me. Listening to the questions, I didn't even understand the questions, to say nothing of the answers so that is why the Bradleys and the Durenbergers and everybody else in this world surround themselves with talented people like that. Then the excuse that we make for our not being able to keep up with these people sometimes, also reflected in the response to one of the questions, "Well, that is not my area."

(Laughter.)

SENATOR DURENBERGER: So we permit them to get by with that kind of distinction while at the back of our heads we know they wouldn't be working for us unless they could probably do better at a lot of these things than we. But Bill Bradley, for whom each of us is substituting in a sense here today, is an example of the unpredictability of the United States of America, and while as business you are a friend to unpredictability, no one would expect that a Rhodes scholar basketball player would end up being a United States Senator and probably in a few short years being President of the United States, but that is the way it goes.

(Laughter.)

SENATOR DURENBERGER: And I have got to toady up to him because I am a Republican and he is a Democrat. I doubt very much whether we will ever find any common partisan grounds on which to stand despite the fact that we have found an incredible impact (inaudible) together, an incredible number of other areas on which to stand, and that may say that in the larger context the unpredictability of the future of this country is a given, not being to the degree of unpredictability as our economic relatedness with the rest of the world.

Bill can't be here because the tax bill is on the floor starting at 2:00 o'clock, and he is generally present, having had at least a philosophical role to play in

reforming the tax in the United States.

But the income tax bill that the House of Representatives passed yesterday and we will pass in the Senate next week and send to the President, is only a mirror reflection of larger economic policy changes that are taking place within the United States of America, and the common element of the policy changes there is a hard line on fair or free trade, on the deflation of agriculture and a lot of basic industries in this country, in many, many areas is serving more efficiency without saying they are serving more efficiency.

I had breakfast this morning with a former college classmate of mine who is president of a railroad in this country, and he is bemoaning the fact that we are moving his railroad from the public utility model, a very definitive model in which the railroad is subsidiary to some larger enterprise in the United States of America, into (inaudible). I said, "Well, all we are doing is the same thing we are doing in everything else," and I said, "We are explicitly dealing with the larger role that society or Government renders in financing access to public or private services."

And so the notion of the second phase of tax reform in the United States is part of a larger philosophic change that is taking place in the United States. Looked at

as a political reform, and pretty soon, the income of the United States, and you understand, those of you who are not from this country, the national government relies almost solely on a tax on income whereas the state governments and local governments in this country tax more than the property law of other countries, but rely on a combination of income, sales, and property taxes.

But the national income tax in this country looks almost like a mountain range in 1981 where most of the people in the country presumably are at the top of the mountains, and their neighbors in the valleys, and this was a political assumption which in some cases had the appearance of reality, that some think 70 percent, or something close, of people were not paying any tax at all. And so the first effort on the part of the Reagan Administration was to cut off the top of the mountain. We did that in 1981. We reduced all the income tax rates in the country by 25 percent and brought the marginal rate down, shortened up the (inaudible), and created an enormous deficit in the country, but at least we brought the people at the top of the mountains closer to the people in the valleys.

This was the second phase of that tax reform which was very simply to bring the people in the valleys up closer to the people at the top of the mountains by

promising the folks at the top that they could come down even farther.

So what we went through was base broadening at the expense of a political maneuver, if you will, which, in effect, reduces the disparity between taxpayers in this country.

But the major effort was to eliminate the tax-motivated subsidies from savings, investment, and consumption in this country, and it is the beginning of a process, not the end of the process.

The way American politics works in the 1980s, despite what the Chairman of the House Ways and Means Committee says, there is no way to raise the rate of taxation of an individual above 28 percent. I don't believe, given that we did base broadening, that it will be possible to raise the rate (inaudible) above 34 percent.

So with a $200, or this year it is allegedly a $154 billion national deficit, and $196 billion dollars are being spent servicing that debt in fiscal 1987, where will the country have to turn in the next few years to raise revenue? The answer to that is more base broadening.

And that, to people in banking and financial services, insurance, and the like, in this country is bad news because it is in those industries, as much as in basic industries in this country -- at this time I suspect the

financial related industries in this country will get hit the next time. How is beyond me, but it is political instinct which tells me that base broadening is the next phase of, or to continue the part of the phase on tax reform, the (inaudible) amendment being the political way that you get the job done. So that is particularly true across the industrial sector.

Now, the good news also is that in the next phase of tax or income tax reform, a major effort will be made to distinguish between earnings that are saved or invested and earnings that are consumed. This country has lived for 30 to 35 years as the engine of western democracy by being a bazaar, and we are today a larger bazaar than we have ever been before, and we have made ourselves into a bazaar simply by putting the commitment of current earnings into consumption rather than into savings and investment.

But the next phase of tax reform will be in the area of preferential treatment in general for saved or invested earnings.

Related to that will be special treatment for health, education, and housing deductions as well.

The third phase is when we do another developing the country's due, and that is when we turn to a (inaudible) tax, and that will in America as in other places take the form of a value-added tax. That is probably out there

somewhere in the early 1990s. That is a natural evolution in a Federal system like ours in which taxes are levied on various enterprises at various levels.

So that is an expectation of the direction that this country will be headed in terms of its treatment of earnings. Again, the philosophy that is behind this is in large part the elimination of hidden subsidies and the explicit payment for public services, public or private services of one kind or another.

Now, the other project that is new in the (inaudible) business, and I won't try to detail it, and I can be responsive in a general way to it, but as the Chairman of the Intelligence Committee for the last two years, I have certainly (inaudible) Bill Bradley's fine effort and his concern for the problems of world debt, and this particularly focuses on Latin America.

The conclusions that he has come to relative to the problems are very similar to the conclusions that we have come to on the Senate Oversight Committee.

They are not necessarily comparable in all respects to the conclusions which the Administration has come to or at least which they have been willing to articulate in some (inaudible).

But the conclusion as far as we are concerned -- you know the President's fetish, and you know the American

people's fetish for Latin America. It is an area which we normally neglect except in times of crisis. We are now in a time of crisis. We were put in a time of crisis in the late '70s by revolution in several countries in Central America and beginning in 1982 we are in a continued and a serious crisis by the condition of the economic burdens laid on Latin America by their debt to western banks which are somewhere in the neighborhood of $370 million.

As to the economic impact of that on those countries, you are better informed, probably, than I on that. The economic impact on the United States, of course, is in the transition in the trade balance between this country and the developing countries of South America, and Central America, and Mexico.

The solutions we all now are difficult to come by. We have come to the conclusion that the conclusions of the -- we call it the Baker Plan for resolving the debt crises won't work, and again at the risk of over-simplification, we have arrived at that conclusion because it doesn't make sense to buy more debt on Latin American countries even if they would succeed in achieving the economic reforms of the Baker Plan demands. Of all debt, if it is still reading correctly as a premise, these countries can all fully repay all the loan they have

outstanding to western banks.

The kind of austerity measures it requires there and the kinds of policy changes that it requires on our part in this country are incredibly difficult to come by, and that is what presents us with a problem.

So whichever recommendation that Senator Bradley has come up with, that there be a consideration and (inaudible) voluntary sector, a consideration (inaudible) with the whole (inaudible) agriculture state, with trying to implore the banking community in this country to consider, and that is in lieu of failure of rural banks in this country, we accept some kind of interest rate relief for some brief period of time, to accept some kind of a writedown and forgiveness of principal on loans for some percentage amount, and in exchange for that, to make some demands, multi-lateral relationship which is both domestic and international term.

And the conclusion which I think has some substantial support in Congress and the United States, but again, it is a view from the outside looking in at a process which none of us think is our full-time concern.

We are a new mix politics, and by that I mean, obviously, (inaudible) politics our full-time concern, and so as these recommendations boil up slowly from members of the Senate, I would suggest that you give them summaries.

Obviously, none of us is in the position of creating a legislative or a political crisis (inaudible) so the best you are getting is an insight which has been bought out (inaudible) in this country, a lot of time on this issue, and we have all put the Intelligence resources of the country and business (inaudible) the rest of the Committee.

This is part of our work in this country today, which is not a hit and miss proposition. It is not taken (inaudible). We have developed in this country in the last year an intelligence strategy which goes way beyond, for the benefit of all of you, I guess, goes way beyond looking at the threat of the Soviet Union as it relates to the national security of America.

The number one concern, probably, today, aside from the Soviet Union, is the problem of world debt and what we do about it.

So let me at that point conclude my remarks, and I will be glad to respond to questions on this or any other subject.

(Applause.)

SENATOR DURENBERGER: Yes?

VOICE: Senator, it has been observed by at least one of our members this morning that the banks, U. S. banks, have not been (inaudible) through Congress. Do you agree

with that, and if you would, how would you suggest we improve our abilities?

SENATOR DURENBERGER: The question has been suggested by someone this morning in this group that banks in America have not done a very good job of communicating their concerns or conditions or whatever to Members of Congress, what I have in suggestions for changing that is, or what mine may be.

I guess my reaction is that I don't necessarily agree with the premise. I think most of what is happening for most of us is that we observe what is happening in deregulation in the larger sense in America; that it is hard to figure out what you mean by banking, and that statement. We are individually concerned about the problems of commercial banking and the loan industry and the investment banking. Most of us, however, apply the lessons that we learned in the specific as far as the institution is concerned, to a commodity or commodities, more a sector of the country in a political sense, in which we have (inaudible.)

There are not many people like Bill who will take a larger world -- the banking community in this country is in the larger concept, and that is (inaudible.) I don't think you have so much of a problem of explaining your problems as coming forward with some helpful suggestions for

resolving that the banking community has (inaudible.) I don't remember the last time I (inaudible), you know, all the political sense in the American banking community since you got through (inaudible.)

Other than that, in the eight years I have been here I have listened, obviously, no reflection on your leadership (inaudible) or the staff of the organization which is terrific. I think it reflects on the institutional rearrangement that is going on in the country.

I mean, from whom do we borrow $8 million? Sometimes we still borrow from banks, but a lot of people are borrowing from Irwin J. Houston, and (inaudible) in this country today.

So we, I think, understand that you have rather substantial problems. What I hope, that by the suggestions we have for resolving some of these things you don't think we are minimizing the problem.

Yes?

VOICE: Given (inaudible) in a comprehensive way information that might (inaudible) addressing all the changes (inaudible). What are the chances of (inaudible)?

SENATOR DURENBERGER: Well, the question, what are the chances -- if we understand that there is a large problem out there and that it doe ve an impact on each of us politically in one way or another what are the chances

of resolving it?

I think the chances of resolving any large problem today depends entirely on leadership. By way of example, the only leader in the Congress on the grain issues inside the country comes either from the protectionists, and they aren't making it, or it will come from somebody like (inaudible) who can rally a few Senators who understand something about trade issues around giving the (inaudible) a hard time until they -- somebody gets down on their knees and (inaudible).

In other areas, I don't know of an area in public policy in America today where the resolution of a set of problems is not so complicated it can't be explained to anyone so the answer is, it is going to take several -- not through the Senate but the Congress -- (inaudible) in the way the bill is (inaudible) the issues relating in this case to world and Latin American debt, and provide some internal leadership (inaudible). I have hired some smart resources. They usually widen your circle -- and get an agreement on the outside. That is the way we did our (inaudible) by the way; we are doing the revolution in financing health care in America today; three or four of us that (inaudible) so we have committed a lot of time and resources to (inaudible).

I will bet you are not used to that kind of answer. The way it has been done in the past, you go to

(inaudible) or something like that, and because they are the Committee Chair, they solve the problem. That can't happen in -- not only in -- and that is no reflection on the leadership of the Banking Commission. It is a reflection on the reality of the banking -- are we to find an impact solely on an (inaudible) process; is sole time (inaudible) the distinction between urban and rural America, a growing problem with long, hard numbers versus small numbers (inaudible) deregulation and deflation.

There are so many of these other (inaudible) change in America that the only way you are going to solve the problem is for a few people who are genuine leaders, who don't care about the national election, (inaudible), who will work to find a solution of (inaudible).

Yes?

VOICE: Senator, as you know, international banks were a little disappointed by the Finance Committee's frequent (inaudible), particularly the fact that the Foreign Tax Credit didn't go (inaudible) to really help spur on more investment in South America. Do you expect that the foreign tax (inaudible)?

SENATOR DURENBERGER: Yes, I think in the next two years there will be a transformation of the form of the treatment in the tax bill of foreign source income in particular.

I don't think, though, that we (inaudible) anybody that cared a heck of a lot about (inaudible) by the pressure to raise money.

All of us represent to a degree American companies that are trying to invest abroad, and that have invested abroad, and the pressure of trying to come to grips with an understanding of what we can do about the Reagan deficit and what we can do about American investment abroad will bring us back (inaudible) some fine day, like the context you are visiting on here today, rather than on the context of how we get a 34 percent rate or a 28 percent rate.

We, those of us who are writing about the international trade, or for that suggestion of that, we need to tie in the tax treatment for foreign source income directly into the (inaudible) about international trade and debt and the (inaudible).

VOICE: Thank you very much.

(End Tape 1, Side 1.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording
Provided to the U.S. Senate
Select Committee on Ethics
by Senator David F. Durenberger

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VOICE: The American Academy of Medical Directors presents this live recording from the 1985 Annual Conference held May 14 through 17. We take you to the Marriott Hotel in Hilton Head Island, South Carolina, where the program is just now beginning.

VOICE: It is now my privilege to introduce our special guest, Senator David Durenberger.

As the senior Senator from Minnesota, Senator Durenberger is Chairman of the Senate Finance Health Committee with jurisdiction over Medicare and Medicaid. This and other unique committee assignments make him in his ability to influence health care policy in the United States most influential.

He was elected to the Senate in 1978 and has brought to it a progressive philosophy that I can assure you is characteristic of most Minnesotans.

He received a Bachelor of Arts degree from St. John's University in 1955 and his law degree from the University of Minnesota in 1959.

Ladies and gentlemen, please join me in welcoming the Honorable David Durenberger, the senior Senator from my home state of Minnesota.

(Applause.)

SENATOR DURENBERGER: Thank you very much. Well, I would like to start out by saying, "I am from the Government, and I am here to help."

(Laughter.)

SENATOR DURENBERGER: And if you believe that, you will respect me in the morning.

(Laughter.)

SENATOR DURENBERGER: And the Part B check is in the mail.

Well, it is a pleasure to be here. I feel a little odd wearing a tie in this surrounding. I understand all the speakers have to do that. All the officers of the organization and all the people that haven't learned how to relax have to come dressed like that.

I fully intended to make a speech, answer questions, and then go play golf, but unfortunately the Defense Department authorization bill is on the floor this afternoon, and in my capacity as Chairman of the Senate Intelligence Committee I have to be on the floor.

Now, a lot of you did not know, I am sure, that the United States Senate had a Committee on Intelligence, did you?

(Laughter.)

SENATOR DURENBERGER: And you are probably

wondering how I got to the Chairman.

(Laughter.)

SENATOR DURENBERGER: Did I win the IQ contest? And so you will really be surprised to know that last year when I was on five Senate committees I was also on one called Ethics. We have both Ethics and Intelligence.

I am here in part because of my special respect for this organization, and its physician executive members; also in part because my publisher has made it possible for me to be here. I have only published one book so far, and I have been spending so much time making speeches I haven't had time to get the second one out which is on a second subject I know something about and will address today which is health policy.

But the first one is called Neither Madmen Nor Messiahs, and it is a book on national security policy which I wrote before I became Chairman of the Intelligence Committee, just to prove I knew something about national defense, and it has nothing in it about $600 toilet seats, but it has a lot in it about why we have to have -- why you had to invite three Surgeons General of three different branches of the Air Force, or why we have to have the Uniformed Military Services Medical School, or something like that; why we have to have a separate system for veterans; why we have to have a separate this, separate

that, and Joel undercovered some of that sort of thing in his remarks.

I also touch on such things as the Div Ad which is a wonderful technological development for the Army, I believe, which does a better job of shooting down latrines than it does shooting down helicopters.

So any of you can find this book at your favorite book store, good luck.

I am also here courtesy of Johnson & Johnson, the wonderful drug company. I notice in this thing that their executives do not get paid as much as the executives at Humanna. Pardon me for that, but they provided the transportation.

I am here to try to provide an elaboration on some of the things that Joel Linder just talked to you about, and unfortunately I didn't know he was going to do that whiz, bang speech, destroying all the myths of health care delivery.

So I only came in at the end of it, and in case I forget to do it at the end of my comments, I want to endorse the second last line of his speech. I heard more than just that, but that is -- this is the way I heard it from Joel. "Physician executives can keep us from going blind."

Now, lots of other people are going to hear that line attributed to Joel because I operate sort of like a

sponge. I am a sponge politician. I was not elected -- I did not run for public office because I needed to be in public office. I was doing much better on the outside when I tried to run for Governor in 1978 and ended up running for the United States Senate, which is an office I never wanted to run for.

So I find myself in large part taking the accumulated so-called wisdom of now 50 years, then 44 years, and interchanging it across the country.

I will squeeze my sponge out on you in the next half hour or so, sort of part of the accumulated knowledge, and then I will relax the sponge and I will listen to your questions, and I am going to learn something from that so that Saturday or Sunday night when I go down to Marko Island to speak to a health insurance group, I am going to squeeze the sponge again on them, and I am going to tell them about "physician executives can keep us from going blind."

I am going to say, "The profession is guilty of the failure to articulate the ideas needed to advance the cause of quality health care delivery and financing." I am also going to say that some day to the American Medical Association. I wish I had heard that from Joel before I spoke to them in Chicago.

And that is sort of the way I operate in the United States Senate, and I would like to suggest to you

that I am not the only one that operates in that area. It just happens to be that in addition to intelligence and some of the environmental areas and intergovernmental relations of which I am also the Chairman, that health policy is an area because, I think, of the Minnesota background, clearly, that I have chosen to use my largest sponge.

Here is what I intend to do this morning: give you a sort of broad overview of where I think things are at i this country and talk about budgets and spending and stuff like that; and then within that talk about what I, at least, would hope to be the future of health care delivery and financing.

I could start with a little story that I used the first time down in Dallas a couple of months ago talking to the outpatient ophthalmic surgeons, and I needed a Texas joke, and I needed it to be short. That is an oxymoron, short Texas joke. So I asked somebody, and they said, "Well, ask them the riddle, why were there so many heros at the Alamo?" I said, "What is the answer?" And they said, "Because there was no back door."

(Laughter.)

SENATOR DURENBERGER: I will tell you, even in Texas they laugh because in Texas they know that those were all Tennesseans at the Alamo.

Then I gave a speech on spending, and after I got

through I said, "You know, it strikes me that the Congress and the President are just like Davy Crockett and the guys in the Alamo. For the last ten years they have been surrounded by 230 people that are clamoring, you know, to cut Government spending, cut taxes, live within your means, balance the budget. Government costs too much, produces too little; the whole system costs too much, produces too little. Do something about it.

That is what got me elected. We elected two Republican Senators in one year from the same state that carried for Walter Mondale in 1984.

So that is what has been going on. Everybody in the country is standing outside the Alamo beating up now on the Congress. What is the difference between the Congress and the President as Alamo and Davy Crockett and his people, and why are there so few heros in a collective sense in the Congress? It is because in our Alamo there is a back door; and every even numbered year we come out one at a time.

(Laughter.)

SENATOR DURENBERGER: And we come to you in the form of a Member of Congress or the Senate up for reelection, and we tell you what we would do to balance the budget, turn this Government around, cut taxes, have fair, fast, flat, simple, you know, tax systems. We have all got an answer, and the answer is the composite of 51 percent of

the people in the electorate we represent.

We spend two years like this, testing 51 percent of the air in our communities, and then come out the back door saying, "If it weren't for that Congress; if it weren't for that Washington, D.C., we, I, you and I together, you know, could change the system."

We have been doing that to you for at least a dozen years. It is we, not you, who have created special interests like this or any other of 30,000 special interests in America. You did not create the special interests; we did. The political system accomplished that, and we did it on the basis of self preservation, self advancement, Lord knows what.

But, anyway, that is the situation in which we find ourselves in America today. Up until now we have not been armed with an instrument to stop this even numbered year exit from the Alamo, but on November whatever it was, 5th, 6th of 1984, we found the instrument.

Ronald Reagan won the election last year with the biggest landslide in, I think, the history of Presidential electoral politics. With the exception of 3,170 benighted souls -- you were not one of them; I was not one of them -- he won the whole country.

The day after that Tip O'Neill took his great big body and went and stood in the back door of the Alamo, and

he said, "You won; we lost; and you ain't getting out the back door of the Alamo. No more of this BS about how individually you can solve these problems. You guys now solve the problems. You tell the people of this country why in four years of the most conservative President in the history of this country since Calvin Coolidge you have doubled the national debt from $715 billion to $1.6 trillion dollars. You tell the people of this country why they ought to live on an annual debt service that has gone from $50 billion in Jimmy Carter's last year to $137 billion a year in debt service this year. You explain that to them. You tell them how you are going to balance the budget with a Constitutional amendment and see if they don't laugh you out."

And that is what Tip said; and that is what, in effect, all the Democrats have said.

So what did we do? We turned to our leader. We said, "Ronnie, you won. You are the guy that won big. You are the guy -- we give up. You tell us how to do it."

(Laughter.)

SENATOR DURENBERGER: And the President said, "That's easy." He said, "Pass a Constitutional amendment." And we did just what you just did now. We sat around at the State of the Union message in the middle of January, and we laughed. And if any of you could sense that on television,

the reality is we laughed.

Immediately thereafter the Republican Senate -- I hope you remember we have one. It doesn't look like it sometimes, but we got together in Blair House, and we said, "That is not enough."

First we got together in the White House, and we said, "That doesn't do it. People have to balance the budget."

So the President then gave us a balanced budget -- or he gave us a budget which took us to a deficit in 1988 of $144 billion, and we said, "That is not going to get us out the front door of the Alamo, either."

So we went to Blair House and made the decision that we as a Republican majority would put together a budget process that would eventually by 1990 take us as close as we could get to a balanced budget.

And at 3:08 a.m. last Friday, a week ago today, we started that process. I won't try to describe it to you other than to say everybody can find something wrong with it, but a whole lot of people can find something right with what we did because we really did start to turn that institution around, recognizing that we should stop going out the back door. We let four of our members go out the back door, Arlen Spector, Al D'Amato, Paula Hawkins, and Mac Matthias. They got out the back door. Ed Zorinski, a

Democrat, stayed in there with us. George Bush cast the deciding vote, and we started the process of turning this situation around.

But that was just a small part of the process, and it was done because it had to be done. It was done because for the first time I think we understood the institutional responsibility that was ours as individuals.

Now, that is one part of the "How do you get control on the spending." The difficulty we have now in moving to the other parts, and I am going to describe them very briefly in a minute, is that most people who think about government spending think like Ronald Reagan; and Ronald Reagan said in his big television speech, he said, "Government spending, that is the real Washington monument."

And he would have you believe that every nickel I spend has at least one cent of waste in it. The American public now believes that except where it affects them. There is no waste in guaranteed student loans. There is no waste in Medicare. There is no waste -- you know, depending on where you are, there is no waste in that program.

But the one we can all pick on is the $600 toilet seats, the $100 light bulbs, the $700 illuminated toilet seats, the pliers, you know; all that sort of thing. And right now 64 percent of the public believe -- 61 percent believes Government spending, my spending, is the heart of

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the economic problems in this country, and 64 percent of them believe that if we cut into defense spending, we would solve the problem.

Well, I am going to try to prove to you that it is not that simple; and by going to the next step, which is another quote from Ronald Reagan the other night, "The answer to a government that is too fat is to stop feeding its growth." How do you stop feeding its growth? Those of you from California know how you stop that: Proposition 13. Those of you from Massachusetts know it is Proposition 2 1/2. All of you know that if you cut off our tax revenue, you can stop the growth of spending.

Somehow, many of you believe that. Clearly, Ronald Reagan over 74 years has come to the conclusion that that is the answer. The government that is too fat can only be stopped by stop feeding its growth.

So that gets us to taxes. Now, let me give you an illustration of tax spending. If we were to freeze, as we are in the process of doing, not quite clearly, but if we froze all government spending, my kind of spending, at this year's level for next year, we would save $31 billion against a $220 billion deficit. That is how small freezes are, just so you put that in perspective.

We have a $220 billion deficit. A freeze would get us a $31 billion saving.

Now, if we froze this second kind of spending, that is illustrated by an advertisement I saw in the Wall Street Journal last December from Cessna Aircraft. They advertise single engine Cessnas, and the headline on the advertisement is, "Two reasons to buy Cessna Aircraft." I don't know what the second reason was, because the first one said, "The IRS will give you all your money back."

It explained how the investment tax credit, accelerated depreciation, the interest deduction, et cetera, would give you all your money back so you can have a free airplane, and they run from -- I tell you this so you can run out and get one before we do tax reform -- they are priced somewhere -- I think the cheapest is about $45,000 and the most expensive is about $220,000.

So if you want to get one at the expense of the rest of the doctors in this room, go out and do it. And apparently your colleagues are willing to buy you one. That is the system we have constructed in this country.

Now, I don't want to leave myself out of the picture, either, because a couple of months ago I went out and bought a second-hand Olds Cutlass Ciera. That is all I can afford on my measly salary.

(Laughter.)

SENATOR DURENBERGER: That goes with my '74 Ford Torino and -- so I went out and bought this second-hand Olds

Ciera, and in Minnesota with sales tax and everything it came to about $9,300.

So I went to my banker and I said, "Borrow me $10,000." That is the way we talk in Minnesota; "Borrow me $10,000." And we all do this. Remember, we need $9,200 so we borrow $10,000 so we can put the other $800 into whatever.

He said, "How long do you want to pay in?" I said, "I want to pay nothing but interest," and he said, "Fine," and so he gave me the same thing you all have done. He gave me this little checkbook, and they are all checks drawn on the U. S. Treasury, and now on April 15 I sit down and I write out a check for one-fifth of the price of my Olds Ciera drawn on your account and I ship it off to the bank.

Now, in five years I will own this car outright, and I will try to remember to come back and speak to you in five years, and thank you for buying me a second-hand Olds Ciera.

So that is an illustration of tax spending. There are 106 versions of that out there today, and the accumulation of all of those next year, or this year, will be $424 billion. If we froze tax spending, interest deduction, charitable deduction, all of that, if we froze that for next year at this year's level, we would save, not

$31 billion, but $44 billion.

So your spending and my spending that is tax-sheltered is going up much faster than the fat cat in Washington who can't constrain his appetite to save the senior citizens and the Army, Navy, Air Force, and Marines.

Now, that is the second part of spending, and you know we have all done that, and I watched one of those morning programs today where some guy is talking, showing that he has got the piggy banks up there, and he is breaking them, and he is illustrating how we are going to go about tax reform in this country. He said, "All the special interests are going to come to us and say you can't get rid of these special interests," and so forth.

But the reality is that none of those tax breaks were put in there because of the special interests. They were put in there for societal good, the good of society.

Why does George Bush pay only 12 1/2 effective rate on his income tax when I paid 50, even though he made $20,000 more last year than I did? Because he did some societal good in Houston. He invested in an apartment building. Now, they didn't happen to need apartment buildings in Houston. In fact, Houston is $22 billion over-built already with George Bush type tax breaks, but society needed rental housing, and so the tax code was changed by the home builders and a whole lot of other well-intentioned

interests to provide that, and George invested in it, and he lost money in it, and he got to reduce his tax obligation.

So the second form of spending that the American public will become sensitive to will be tax spending, once we get into tax reform. If you want to ask questions about that later, I would be happy to respond to that.

There is a third kind of spending, and that -- I should mention before I forget it, there are actually six of these so you know how long I am going to speak.

But the one is the one I want to remember because I was reminded of it in my last speech, and that is just charitable spending, volunteerism, the kind of things where we go into our pocket to help our neighbor, and that has been with us as part of our culture from whatever ethic origin we come.

Now, the fourth kind of spending that we do well in this country is regulation. That is a phenomenon that goes way back to the 1880s when we found we were being abused by big railroads in this country.

For example, we created the Interstate Commerce Commission. We found a way to preserve big railroads and keep little railroads out, but in other ways to get railroads all over the country without abusing us.

And we adapted that to a variety of things in this country over the last 100 years, ending up with the

environment and occupational safety and health and equal employment opportunity and all that sort of thing; and those accumulated costs are enormous in America.

But they are a way to get each of us to spend something to protect a larger public: or they are a way for us to use in the hospital sense, or doctor sense, to use the ability of those who can pay to provide services for those who can't pay; in other words, the poor, medical students, technological development. None of those are financed explicitly in this country, or not very well. They are all sort of hidden under the cost of my access into the system.

So regulation in that way is a way to get us to spend money.

Now, there is a fifth way to do it, illustrated by the fact that -- there just happened to be lying on my table up there this Executive Pay issue of Business Week. Why did Lee Iacocca get $5,510,000 last year? Why did Phil Caldwell at Ford get $4,060,000? Why did my friend, Don Peterson, from Pipestone, Minnesota, who is also at Ford, get something like $2 1/2 million last year? Because their companies did well.

Why did their companies do well? Well, their companies did well because four years ago they were able to convince us that if you wanted to preserve an American automobile industry, you had to keep the competition out.

So we did it.

How did we do it? By keeping the competition out; by denying the American consumer the right to buy quality automobiles rather than chrome or whatever we buy from Detroit, we kept the Japanese out.

We added, at the most conservative estimate, we added $700 to the price of every American automobile, and about $1,300 to the price of every Japanese automobile. You won't find it on the sticker price of any car you buy today, but it is there. We saved 26,000 auto worker jobs at $23 an hour with their fat, fat, fat, health insurance benefits that I shouldn't even call health insurance because they are not. They are a big rip-off.

We saved that, 26,000 of them, by adding $700 to the price of every American car you buy.

Now, we do the same thing in the hospital business. We do it very well in New York. We do it very well in Massachusetts, New Jersey, and Maryland; maybe less well in some other states, but by enfranchising the existing delivery system, we -- and keeping the competition out, we make sure that we can continue the subsidies of inefficiency, the subsidies of the poor, the subsidies of medical education, the subsidies of whatever, by raising, controlling the rise in the price of the product that is delivered by those hospitals, doctors, or whatever.

I could go into other industries, but I think you have the point that there is another way to get the American public to spend money to achieve some perceived good; i.e., take care of the indigent in hospitals, like who spoke to you from NYU? One of those kinds of hospitals; and/or save 26,000 auto worker jobs and pay $5 million salaries to a guy that could live off his book. He doesn't need those salaries.

But that is how we did it. Now, that is five ways to spend money, and we have done all of these.

The sixth way is the one that gets us into health care even more directly, and that is the legacy of my parents' generation to my generation. My parents decided to have me in the Depression at a time when they couldn't have anything but kids. They had trouble having a home, and trouble having a job, and trouble having food on the table. And they swore after the Second World War that would never happen to my generation.

So in the political sense and the societal sense they decided that I would be the "have" generation. I could have a three-bedroom home in the suburbs with a recreation room and two fireplaces, three in Minnesota -- whatever are in the basement, you know; you name it. I could have all of that for only $500; $500 down, 30 years to pay, four and a half percent interest rates, all of it deductible on my

income tax, I could have. America woke up to the fact it could have a castle for $500.

So everybody my age stood up with their $500 bills and said, "I want one." All over America we were waving our $500 bills, and it turned out, there were only half as many houses available a there were people with $500 bills. So what happened? We had the rush to build homes.

How did we rush to build homes? We raised the prices of all the construction workers, all the construction products, all that sort of thing. We kept her moving, and of course we raised the value of everybody who already had a house.

So I bought my first house for $8,500 and in three years I sold it for $20,000, and I put $11,500 in my pocket; took $500 and bought myself another house. In three years I sold that one for $50,000, and I put $30,000 in my pocket, and started a business with it or something like that, and went out and bought another one. You all know what I am talking about. We have all done that. That is the benefits of my generation. In health care we did the same thing.

In 1954 the Government blessed the employer/employee arrangement as the best place to buy health care, and we destroyed the economic incentives to practice medicine, to deliver hospital care efficiently, and

more importantly, we destroyed my personal incentives to stay healthy.

The Government decided at that point in time to give the employer a business deduction for health insurance premiums and to treat the amount of that payment by the employer as tax-free income to the employees. At that point we were off to the races.

We then were delivered first dollar coverage and the destruction of health insurance as a system in which we protect ourselves against financial catastrophe. We converted the health insurance system into free health care. Anything that had the word "health" got into those policies, and we didn't pay for it.

When I went to work at the H. B. Fuller Company in 1970, my paternalistic employer gave me my health plan. I didn't even look at it because by then I had been so insensitized to what my contribution to the health care system, I just took the plan, stored it away someplace, and the first time I found an ache in my body I went off to the doctor, and I sat there and I consumed all the doctor's services. He told me to go to a hospital; you know, "Spend the weekend in the hospital, and we will look at you on Tuesday or whenever we get around to it."

(End Tape 1, Side 1.)

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SENATOR DURENBERGER: It never cost me a thing. It was the impatience of paper work. Yes, it took a little while to process the paper and all this sort of junk, but it didn't cost me anything to get sick. It didn't cost me anything to smoke two and a half packs a day, if that were me, for 25 years. But that wasn't me. It was Barney Clark, famous dentist, who bought four extra months of life out of the Medicare trust fund. That was his reward for smoking two and a half packs a day for 25 years. That is my generation. That is all we understand.

You don't have to ride a helmet when you ride a motorcycle in America because some good doctor, hospital, and this set of blank checks, you know, will take care of you. You don't have to wear safety restraints in automobiles because somebody will take care of you. Your employer has a plan. Somebody has a plan. There is Medicare, Medicaid, what not. There is a plan to take care of you.

All of the rewards to my generation have been in getting sick. What are the messages I grow up on?

The messages I grow up on is that if you end up in a hospital, that is the best place in the world to be. They send you flowers; people come to visit you. You know, everybody is very nice to you. Your employer says you can go and lie in the hospital forever. It doesn't cost

anything. We will continue to pay you. If you go to work, you have to work for your money.

That is my generation. That is what we have learned in this society.

So how do you raise the price of a doctor? How do you raise the price of a day in the hospital? How do you raise the price of a drug, diagnostic equipment? You do it with inflation. You do it with an excess of demand over supply. Run it up. Now it is up to a billion dollars a day, and we are all sitting around complaining. Why does it cost so much?

The first thing we do is point to the doctors. They all drive Cadillacs or Lincolns, and they have their conferences in fancy places like this. Go get them! Or the hospitals; why should a day in the hospital cost $1,000 in California and $500 in Minneapolis? Why?

So we as a society pick on you; and the reality is, as I have explained it, that we have found a way in my generation to have today and send the bill off to tomorrow.

So those are the -- I think I have now covered six ways to have. Have apartment houses; have cars; have boats; have $600 toilet seats; have separate Surgeon Generals for each of the -- have the useless Academy of Medical Colleges in Bethesda, Maryland. Have a separate Veterans Administration system, you know. That is what we

have done.

The problem now for all of us is simply the legacy that we have left to our children. My children are not going to have access to the same health care system I had. My children are not going to have the same interest deductions that I had. In fact, my children won't be able to afford a house. They can't; they just can't do it. I think maybe eight percent of the kids graduating from college this year would even have the capacity to make a down payment on a home; or maybe it is six percent or something like that. In one generation that is what we have done. My kids now have to come and rent from me. That is what we have done.

And we have done the same thing in the health care field, and we have done it all over the place.

So we are now in the process of turning that around. One of the interesting things that was illustrated by the debate on the budget is some of the hurdles that, if you choose to take Joel Linder's advice and you choose not to go blind as a profession -- and I am here to tell you, please don't go blind -- one of the things you have to understand is that Washington is always a few years behind the rest of the country, and it is a big effort on your part to get us up to speed; you know, pull us along. To the degree that you sit on your duff and don't pull us along in

some way, it is going to take us longer to get there.

So we will do some fairly silly things like promising you that we are going to pay you if you buy into prospective payment system reform and then freeze, you know, the COLAs, or freeze Part B, because we haven't been educated to the role that you are willing to play in the delivery of health care, and that is your fault.

Now, I am okay; so the guys from Minnesota get a free ride, but the rest of you got problems on my colleagues, and I want to emphasize as much as I can the bottom line that I heard from Joe, and unfortunately I didn't hear all the rest of it -- but if you don't want to go blind, and you don't want your patients to go blind, then you better take the blinders off of the rest of the politicians in Washington.

Now, one of the blinders is this. Ronald Reagan and a lot of other people believe in the Constitution, and they believe in the literal interpretation of the Constitution. That is that the Federal Government is a creature of the states and that it exists to provide for the national defense, protect us from pirates, build post roads, and that sort of thing. There is a part in there about controlling the currency, but I don't think he believes that. If he does, a lot of good conservatives don't; I know that.

But there is in Washington today a literal effort to dismantle the Federal Government. They are stuck with debt. They are stuck with the social security system, and they are stuck with -- not stuck. They want to be in the national defense business, and we all need to be in the national defense business. That is it! Get out of everything else.

Now, we got out of 12 new lines of business. In the last four years we have got out of 142 lines of business. We have gotten rid of 140 programs that we created in the last 20 years, and the debate last week was on doing 17 more fairly big ones.

I will just give you one little insight into the problem. Amtrak we debated for only 30 minutes, equally divided; 15 minutes for the proponents of getting rid of Amtrak, and 15 minutes for the opponents of getting rid of Amtrak, and Bill Armstrong took the proponent side, and he said that if you want to ride a train, you ought to pay for it. In other words, we ought to have a user systen for our national rail passenger system. We won't have a national rail passenger system unless people are willing to pay for it.

Joe Biden from Delaware got up. Obviously, a lot of Amtrak trains go through Delaware or Joe wouldn't have gotten up, but Joe got up, and he made this point.

Joe said, "How about water for farmers in Colorado? Are you willing, Senator, my dear colleague, my wonderful colleague, are you willing to have all those Colorado farmers pay for all their water?" And since Bill was not voting on water for farmers, he said yes.

But therein lies the rub. What are we going to do when we get to that water? What did we do last year when we continued a subsidy for California and Nevada, Arizona water, hydro power, at one-tenth the cost that I pay in Minneapolis? Who was the leader on that one? Paul Laxalt, the most conservative friend of the President. Barry Goldwater, a traditional conservative. They all said, "Maintain that subsidy, California water."

We are now into, and we don't know it yet, but we are starting into the rest of the iceberg when we start to debate national purposes. Should we or should we not have a national rail passenger system in this country?

Then the question becomes how are we going to get it? Are you going to spend money on Amtrak to get it? Are you going to use tax breaks? Are you going to use something else?

I think we could have a national rail passenger system if we would quit subsidizing the automobile. That is what killed trains in this country is the huge subsidies for the automobile.

Well, now, Ronald Reagan wouldn't agree with that, I suppose. Maybe a lot of other people wouldn't, but that is the debate that will have to go on.

As that is translated into the health care field, the national purposes that we will debate are, first, intergenerational equity.

In the traditional sense in any society each new generation takes something from the preceding generation, and when it is ready to leave, leaves something behind.

My parents traditionally have left something behind for me. I leave something behind for my children. My children when they come into this life take something from me: education and health and all that sort of thing. That is the traditional way we have done it, but we are about to break that link in America today.

My parents live in Clearwater, Florida, much better off than they ever did when they lived in Collegeville, Minnesota. But they lived in the Depression. They fear catastrophic illness and a lot of things and so they are going to want to have. So my kids are going to pay 14 percent off the payroll tax for social security so my parents can live without fear in Clearwater, Florida, and that 14 percent may end up at 30 percent before they are ready to retire themselves, at which time they do not expect their to be any social security there for them.

So that intergenerational problem, the fact that my generation is going to be the fat generation. When I get on retirement, I am not going to have anything to worry about, but my kids are not going to have the system at the rate we are going. That is a national purpose. How do we deal with that? How do we dealing with the ageing of the U.S. population in that regard? We don't know how to handle -- we are just starting in to handling the acute care system. We are now going to start struggling with sub-acute care. We haven't even touched long-term care. We have no insurance out there for long term care. The whole system is a mess. We are using expensive health care dollars to provide shelter and nutrition and stuff like that. Dumb, dumb, dumb, waste of resources. We have to tackle that issue.

We don't know anything about retirement cash. How much 401(k) are we going to have, IRAs, Keoghs. Are we just going to pile that stuff up? How high do you want to pile it, through revenue foregone and all that sort of thing? Those are issues we haven't begun to address.

The indigent. Now, you all know what happens in your practice, in your clinic, in a hospital, when we go to price competition. We expose all the subsidies. If you can't transfer money from my hospital bill to take care of the poor, you are in tough shape. If you are in downtown

Chicago or New York or Detroit or Washington or something like that, you are in real tough shape if all the suburban hospitals are getting all of the good business, and all you have got is the poor. You can't make it.

We have to deal explicitly in America with the problem of the indigent. I can't see how we can maintain the subsidies and also have competition that has some kind of a price on it.

The first thing we have to do -- well, let me just illustrate what I learned in Detroit with my sponge operating in Detroit last week when I talked to the Economics Club in Detroit. I first met with the hospital folks in Detroit, and they told me last year in southeastern Michigan they had $86 million in bad debt, $22 million in free care, and $12 million in Hill-Burton. That is a big chunk of money in one area.

Paul Broughton who runs Children's in Detroit said, "Senator, do you know" -- first time I heard this. Wish I had been more sensitive. He said, "Do you know what the biggest killer of kids was last year?" I said, "No." He said, "Poverty, 10,000 of them died of poverty." Man, that is a telling figure. I think you all know that one. In this group it is a figure added to the dimension of a problem I think you understand.

But unless we at my level acknowledge a

responsibility to the poor and the indigent, we aren't going to solve this problem. Right now we are out of cash. The states allegedly have surpluses so we are not willing to acknowledge our responsibility to the poor. It is a difficult situation.

There are a variety of ways we could do it. There are no magic answers, but I am just here to tell you that that is a national purpose that you, if you care, must force on your national government; not that we have to raise all the money. We just have to make more sense out of the system we already have. We are spending over $100 billion a year on the indigent in America, but I will bet we are wasting a whole lot of it.

We will not put money into maternal and child health the way we ought to. We will not put money into that poor, black, first time mother who needs to understand something about nutrition, how to take care of her body because of what she is carrying. We won't put the money in there, but we will put it in $4,000 a day neonatal intensive care incubators, won't we? And we will take that little baby out at, what, 750 grams? Is that we have got it down to now? Wonders, wonders, marvelous. But we won't recognize the best incubator of all is right here, not in me, but in the women. Huh? Oh, man, that is terrible. And I could do something about that at the Federal level if I

would build prevention and wellness and so forth into these programs.

But I am out of money. It costs some money to do this, but I am out of money because the drain on the acute care side is so large that it is hard to do it, without your help. That is the indigent.

How about graduate medical education? You don't know it yesterday, but finally we put in Dole-Durenberger-Bentsen yesterday. It looks a lot like, but isn't identical with Peters-Dorfen-Heizel, so I won't try to explain the whole thing.

But in effect it is better than the old block grant bill that I put in that all of you dumped on. Not all of you, but a lot of you did, probably appropriately. The old block grant bill simply said, "First, gang, I need help. I need help. I don't want to try to educate doctors and nurses and health professionals in America because I have done such a lousy job of it in the past. I want to be relieved of that obligation. Also, the old way we have been doing it where you do as much as you want of whatever you want. You do 17 percent of it in New York, and 12 percent of it in Boston, and all that sort of thing, is producing too much, or costing too much and producing too much also, I guess. I want somebody to get a handle on it, but you are not getting a handle on it because there is no explicit

costs. There is no way for society to interface with the way we use those resources."

So in effect what our bill says is that we will convert Medicare, after an '86 freeze, in '87 we will convert Medicare's role to paying on a hospital specific basis in the beginning, at least -- we will carry the resident and the intern up to board specialty. After that you are on your own.

And that is about an equivalent amount of dollars that we are now spending for the whole works, maybe slightly less. But that is our basic position, and it is interim. That does not solve the problem.

It is an interim indication that we want Medicare to pay, quote, "its fair share," but we want it to be more explicit.

Now, we will wait for everybody else to tell us we ought to do it differently. All we got from the block grant approach is, you dumped on us and you said you don't trust the state legislatures and all that sort of thing, so I learned something from that, but I am not backing off with the idea that the states and local communities and the professions have to be more involved in medical education.

In research, we have got the same problem. We have to acknowledge a national responsibility for basic research. Applied research we can get because there is a

profit in it, and the drug companies, or whatever. But basic research is a national responsibility. You can't have a society that says, "We don't have a national responsibility to find a cure for cancer," for example.

High tech and drugs, I guess the wonder is the price has never come down. Everybody carries around a little calculator with them that, you know, when they first came on the market five years ago, those calculators cost you $200. Today they are plastic with micro chips, and people give them away.

Has that ever happened to a new piece of diagnostic equipment? Has it ever happened to a new wonder drug? Hell, no. Prices just go up. They never come down, and whoever invented it got their money back in two or three years on the market, and the prices never came down.

But you know who gets the blame for that? You do. They don't; you do. They get praised for their creative genius; you get blamed for the high cost of diagnosis, treatment, and what not else. I think you have a stake in that, too.

Capital. Lordy, where are we going in the cost of capital? The market came down; the prime rate came down to 10 percent in one bank. Maybe it will come down in the rest of the banks. But the high cost of capital is really skewing the delivery system in this country. That is a

national responsibility. The quality of health care is a national responsibility.

We are undertaking a responsibility to help you change physician practice patterns in America. We acknowledge that to be a quality problem. The over-utilization of health care service is a problem to me as a consumer.

You have to help us with the job of a more conservative practice of medicine. We have to help you with the problem that you have in applying your professional judgment vis-a-vis your colleagues.

If I have heard it once I have heard it 50 times as I go around the country. Medical staffs of hospitals trying to help the hospital discipline or keep privileges away from somebody who should not be practicing in that hospital, but they can't do it because the somebody involved says, "I will have your what-you-may-call-it in court tomorrow." Right?

That is what is happening to you, so hard as you try, you know, to discipline yourselves, we have a system in America that says, "Everybody has a right to do whatever they please if they have got a license," and there is a lawyer right behind them. In fact, there is 10 lawyers right behind them, you know, willing to stick it to you.

It is a national responsibility to help you do

something about that.

Licensure, traditionally a state responsibility, but the standards with regard to licensure maybe have to be national standards. I don't know. Malpractice; I mean, it is -- if it weren't so sad, it is getting to be -- it is funny in the way the malpractice system works in this country. One court suit, and every OB/GYN has their premiums doubled; and it quadruples them in Michigan and only doubles in Indiana, or something like that. It just doesn't make any sense.

But I am stuck with that is a state responsibility. Somehow you have to help me by helping my colleagues understand there is a national responsibility.

I am going to finish -- I have talked much too long. Who dictates professional judgment as applied to patient services in America? That is a question I can't answer except by way of personal preference. Here are the questions. Will they be dictated by Wall Street? I was on Wall Street on Monday of this week. I sat down with the best, the younger people who really make the decisions on financing hospital bonds, for example; and after two hours with them we all walked out of the room just scratching our heads. We don't know whether we are afoot or horseback.

We don't know how to finance the future of hospitals in this country, but we know that in Wall Street

they have got control of the money. They can make those decisions, and they are cutting off hospitals right and left, boom, boom, boom, boom, boom, boom, boom; just like that. And they are very uncomfortable about the way they are making those decisions, but access to capital today is going to make a big difference on who is going to make it and who isn't going to make it.

Do I feel comfortable with those decisions being made on Wall Street? Of course not; of course not.

Money. What is the horse that won the Kentucky Derby? Spend-A-Buck; okay. Maybe you saw it on one of those morning shows this morning; the big debate about the fact that he is now going to the Preakness. Well, this guy Brennan, you know, from New Jersey who flies around in a helicopter and lands it next to dams and things like that. Well, you know, it is him versus horse racing. He clearly is in the money-making business. He is portrayed as being a person who doesn't give a damn about horse racing. He only wants to make money.

What are we going to say about Humanna, HCA, Sears Roebuck when they get in the business, General Motors when they get in the business? Are we inclined to believe they are more like Brennan than they are like the people that love medicine?

Well, you can't say that about Tom First because

you know his dad. See, so you don't want to believe that, and yet you are haunted by that fear. Paul Ellwood says in just a few years there is only going to be 30 big health plans in this country.

I suspect in five or six years there will only be six or seven really big ones. I suspect General Motors might be one of them. Sears, Roebuck might be another. I don't know; that is possible. But do I believe that that automatically means that Brennan wins and there is more money going to the Jersey stakes than there is to Preakness who is going to win in health care? I can't believe that. But if I were you, I would worry about it. And I worry about it.

The third. Will the consumer dictate that professional judgment be applied to patient services? That, I think, is the answer. Now, that is the answer you are most comfortable with because if the consumer gets to make the decision, then you are in the driver's seat.

If we enable you with the ability to apply professional judgment to the consumer, if a health plan is constructed so that it rewards quality as well as price, then the third one is the answer.

And there I would suggest that John Burns at Honeywell and I don't know who else may be here representing the employers of America, but they become the key. They

screwed up this system for us. They have to find the answer to it, and the can find the answer to it through consumer choice in health care. If they provide the opportunities for their employees to buy a choice of health plans, and they go beyond just forcing cost sharing and second surgical opinions and all that sort of thing that they have been doing, and they make sure that those health plans deliver quality specialty as well as primary care services; that the choices that their employees make are dictated by quality as much as they are by price; and that those health plans that don't deliver that are not in their employee market -- and they will get plenty of cooperation from their employees because nobody wants to buy a perforated ulcer or, you know, a mangled anything.

That becomes the key, and on the way they are going to look a little funny. I mean, some of these employer groups are just out to be doctor bashers. I mean, and I see them all, the employee benefits people, and they just love to get at you guys.

I mean, they are just like a Senator at $75,000 a year who waves around $18 million salaries. "I can't wait to get at them." See? Well, that is the way these employee benefit guys are about doctors. Finally they are going after you; see? And they have made a whole industry out of second surgical opinions. The thing everybody ought

to be in is second surgical opinions. You know, the second guy around always gets to be the winner.

That is not the way they should be going. You know, there is a transition, just like peer review is a transition to something else. But they, I believe, they hold a key to that issue of who. Wall Street, the for-profits or money, and I shouldn't say both of those words in the same breath, please, because I think some of you know where I stand.

I think the whole hospital industry, like the doctor industry, ought to be for profit. I don't know how we would get there, but I mean, everybody ought to make a bottom line of some kind. I don't know how we get there past the nons and everything else. I am not quite sure. But that is the directior we need to go.

Well, I am sorry. I had some other notes here about Medicare and all that sort of thing, but please allow me to quit at that point.

If there are any questions left, those of you who have to go to the bathroom or play golf, I will see you, but maybe somebody --

(Applause.)

SENATOR DURENBERGER: Thank you.

(End Tape 1, Side 2.)

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PROCEEDINGS

VOICE: -- please welcome Dr. Angelo Spoto, AGPA Trustee.

(Applause.)

DR. SPOTO: Thank you.

Dr. Knutsen could not be with us today because of a recent death in the family.

Our session this morning will be on health care systems perspectives. The poet has said seek not the trodden path, but create a new and perhaps a better path so that others may follow. The turbulent Seventies and Eighties in health care produced health care systems which are major players in our present health care delivery system. Like the perspectives of labor, business, government and organized medicine, these health care systems will impact on the way group practices function in the future.

This general session has been designed to explore health care from the perspectives of these large health care systems.

As Administrator of the Health Care Financing Administration, Dr. Carolyn Davis oversaw the financial health care services for 34 million poor, elderly and disabled Americans in the Medicare and Medicaid programs. During her leadership, HCVA implemented the DRG prospective

payment system, the peer review organization program to monitor utilization and quality of care, the development of rules of coverage and reimbursement of ambulatory facilities as a cost effective alternative to in-patient hospital services and many other programs which helped to control the rise of health care costs while assuring continued quality care for the Medicare and Medicaid population.

She is at present a consultant in the Health Care Division of Ernst and Whinney. Please welcome Dr. Carolyn Davis.

(Applause.)

DR. DAVIS: Thank you.

You know, all of you love to criticize what's gone on in terms of the regulatory development and I really felt that since I was a part of making those regulations and signing them it was very difficult for me to criticize them for a long time. However, they have done one thing to me. They have now forced me by dint of reading those -- for such long periods of time, to be able to see what I'm going to say I'm going to have to resort to glasses. So, at long last I can blame something on the regulations, too.

In the decade of the Eighties I think, as all of us would agree, we've seen the most change in the health care delivery system that we've seen in the rest of this century put together, and so what was once the status quo is

now no more than a dream rememberd. And I suspect many people have two emotions as a result of that. Some have nostalgia, a remembrance of what has been and will never be again, and others have a grief reaction. The loss of something very significant to that person. I think the grief reaction is still in the stage of denial. It can't really happen. Hoping the DRG's will go away. Or it won't happen in terms of movement to managed care. Or then we've got the anger phase where -- we all know how that is acting out.

But eventually one moves through those stages to bargaining an acceptance and a willingness to work to make the new system work, and I think that's where we need to focus our efforts because it's only 13 years now until a new millenium. And I wanted to really look at that new millenium as it begins to shape itself and arrive and look at what major events shape our health care system as we move toward the new millenium. I think there are two in number. Obviously, financing for health care will really shape the way in which health care is delivered and, secondly, I believe that a new and renewed focus on a review of quality of care. Beginning to ascertain what the outcome measures are in terms of appropriate care will be the two major factors that move us towards this new millenium.

In the Medicare system people have said, well,

DRG's are an interim and hopefully they'll go away. Well, I would say the system probably won't expire soon because what would take its place. Yes, there is a move towards capitation and toward vouchers. But it's not likely that Congress or the Administration will mandate that a move in this direction occur, but rather will do everything they can to encourage its gradual evolution.

So that leaves us with a prediction that by 1992 70 percent of our population, both privately paid for and government paid for, will be enrolled in some type of managed care systems, with the bets pretty well splitting as to whether the HMO's or the PPO's will take over the fastest growing segment.

Vouchers, too, will come along in the near future. There will be more experimental work done in relating to the development and testing of those voucher systems. But I believe it will be the mid-1990's before Congress will be comfortable enough with the concepts of the voucher system and having felt it had been tested enough to move to actually accept it as a significant payment reform. And so, in the meantime, we can look forward to continued fixing about the edges of the DRG system, for one, and a move towards a fixed payment insentive plan for all other parts of payment reform.

Now, in terms of the DRG's itself, I believe that

in the next couple of years you're going to see attention towards redistribution within the outlayer payment system. Probably a move upward from the 60 percent payment. And secondly, a look at the area wage differentials in an effort to reduce the spread between urban and rural hospitals.

Undoubtedly, in two or three years time there will be a methodology that will be acceptable as a severity of illness index measure. But in the meantime, I think that the move will be towards decreasing the disparity between the DRG's by simply looking at the outlayers and reducing the spread between the urban and rurals. Right now the University of Michigan study is about to be -- well, it has been completed and it's being reported at this time to the Health Care Finance Administration. And this is the study, as you remember, that was looking at comparisons between the severity of illness measures to determine the methodology application, realibility and predictability of the various severity indexes from Horns work to Wanda Young's Patient Classification System, the Apache Disease Staging and the Medicine Group System. All of those are being evaluated. But I do believe it will take a couple more years before the final results are in.

You already heard David Durenberger indicate that he thought that they had done what they could in relationship to the graduate medical education component.

It is my belief, however, that in the next several years you will see a decrease in support for graduate medicate education in two ways. First of all, I suspect that even this next year you'll find that the indirect medical education component will probably move downward from the 8 percent to the 5.79 percent passthrough because of new data that is coming forward from the GAO study, as well as HCVA's studies, and then a gradual move in the reduction of the direct medical education support base. Mostly because, if you read the tea leaves at all, you realize that the budget is the major driving force in terms of shaping health policy, and the budget for Medicare, although it's solvent now, will be insolvent by 1996 or 98, depending on whether you are the pessimist or an intermediate assumption person. But the government has to go on the worst case scenario and that means 1996 is the bottom update.

That means that they must continue to try to reduce the outlays in this interim time period, and with $3.2 billion sitting in medical education and the surplus of physicians, I believe that it is an area that they will continue to look at towards restructuring downward in the support base.

Senator Durenberger mentioned capital and I would agree with him. I think that will be fixed in the near future. But then moving from that, I think it's important

to know that although the major discussion points have been on what rate to pay the hospitals and will probably continue in the near future in that, that much more of the emphasis in the next decade will be towards looking at how you redistribute within the DRG's. A hundred DRG's make up 78 percent of all discharges, and so become easier and easier, as we collect more data on those discharges, to actually focus on those and to be able to adjust them, particularly now that HCVA has indicated they will rewait each year. TVhat allows them to adjust the specific weights for technology.

So, as we look at how they are looking at the payment to hospitals, I think it's also important to recognize that as they reduce the payment to hospitals there's been increased concern for the quality of care. To make certain that that quality of care does not erode it will mean expanded review for quality assurance. Expanded review, as you know, is already coming about through peer review expansion of activities.

And I think in the next two years time you're going to see a significant looking at how we determine outcome measures of care. Congress recently placed $12 million in the National Center for Health Services Research Budget. $12 million can do a great deal towards helping us to sharpen our research activities as they relate to quality

of care outcome measures.

Many individuals have indicated that quality of care is somewhat like pornography. You know it when you see it, but you really can't define it. Well, I suspect that $12 million will help us to define it a great deal in the next several years. It is the specific criteria that will be being developed that I think will guide us into the far future in terms of quality of care.

Meanwhile, we are living with generic screens. The new generic screens will focus not only on mortality rates, unexpected return to surgery, but also discharge planning. Was it adequate. Was the patient physiologically stable and appropriate for a move out from the hospital itself. And what about trauma within the hospital? Medication errors and falls and those succumbing to infections. It is all of that data that given a year of collection will then become public information under the freedom of information laws.

In the business community and the beneficiaries are saying that's the kind of data we want in order to help us to select our providers of care. Recently the State of Pennsylvania, it's business community and its health care providers, got together and designed a data base system. It is legislated now and they're off in terms of collecting 28 data points to allow business communities to asses where the

best provision of care is being given within their state and within which specific providers.

Another example I could use is Honeywell Corporation, which recently in its request for proposal for a bid for preferred provider options, or HMO coverage, have indicated for the first time that in order to qualify for that bid you must be able to quantify the outcomes of care in order to sustain the fact that you are giving good quality care. That's one of the first requests for specific outcome measures that I have seen from the business community and I think we will continue to see that in the future.

Meanwhile we are faced with a significant dilemma this very year, and that is, Congress mandated in the recent legislation the denial of payment for poor quality of care. That is a large hot potatoe, let me tell you, because it's one thing to define that somebody has an assumption that there might have been poor quality of care given, it's another thing to deny payment as a result of that, and while the intention may be very good, think through with me what will happen. Somehow HCVA determines through its peer review process that poor quality of care was given and, of course, if they are to deny payment a letter must go to the beneficiary.

Now, if you were a beneficiary and you got a

letter that said, we won't pay for your care within the hospital because it was judged to be poor quality, I leave it to you. I call it the Lawyers Full Employment Act.

(Laughter.)

HCVA is being very cautious with that. They are looking very carefully at how to set up criteria for poor quality care. They are trying to look at establishing a two-tier review, if you will, even before they move to decide that it is indeed poor quality care, and then moving to an appeal process. In all of those things they're hoping to reach out and involve the physician community in order to help to set these particular standards.

It is the law. They cannot help but enforce it. There will be hearings next year if they don't enforce it. There will probably be hearings even if they do enforce it. But nevertheless, I think you can look forward to some understanding from the part of the Department in terms of trying to work with you to develop the correct criteria. But it is a problem that we will need to address in this near future.

Since marketing is nothing more than positioning in the mind of the consumer, it is important to recognize that many hospitals are now collecting quality of care data with an eye towards marketing. They fully intend at the end of the year of collection of their quality of care

indicators to put that forward as an indication that you ought to decide to place your affection and affiliation and care needs with them because they have bonafide, legitimate, quality of care being given by virtue of listing the criteria.

Now, I leave it to you to interpret. But it seems to me that in this day and age of competition, what it really means is that more and more physicians will become involved at the grass roots level in terms of trying to define criteria for good quality care, not only focusing on outcome measures but focusing, too, on helping the individual group practice or the individual hospital or a combination thereof define the quantified measures of outcomes of good quality care that they wish to measure.

Nesbitt, writing about the future, has indicated that the future is an information-based economy, and I think health care is a major target. In order to expand its use of an information base system, I see a significant expansion in the next five years in terms of the use of computers. Yes, we are now very comfortable with the hospital computer system, tracking and storing data relating to the fiscal cost per case and even some related to clinical merger of data base.

But in the future, I think that linkage will go much further. We will really truly have a health care

system without walls built around the hospital part as the reduction and occupancy has occurred and the utilization and managed care. As you know, if 400 beds per 1,000 -- and the national average right now is 900 beds per 1,000 -- it doesn't take many a wise man to determine that if that drop is that significant the occupancy rate will go even lower. And so we have the fever of diversification going on in the hospital market with the attempt to have an all provider, all encompassing continuity of care system.

But the linkage between those points will be most important, and it is with the computer that we will find that new linkage occurring. The computers will appear in the near future at the bedside and the record as we know it, that hard paper copy record will disappear as we all become more and more comfortable with the computer age. It will be an important asset for all of us because you can input in terms of the kinds of testing, the kinds of activities that are done right at the bedside of the patient.

In addition, one can acccess into that file from all remote points. Off campus, too. From the office, where one can sit and review the clinical signs and symptoms and, yes, even from integrating systems from the large to the small so that the rural hospitals and the rural physicians will be easier served in terms of that linkage. And also, we're within striking distance of relating to the patient in

their home with the computer. It's now being built in a prototype model. The estimation is that for $5 a month a physician may link to the patient at home in a interactive communication system.

Think of the ability to be able to daily link to your patients at home, to be able to by a simple coded telephone message talk with your patient at home on that daily basis. It's not far away. There are those who are designing it even as we speak.

And what about a program designed to assist the elderly or the others who are forgetful in terms of reminding them to take their medications at specific points in time. We all know that compliance with medication therapy is a very difficult regime for the older person and, yet, telephone computerized system can easily be adapted to plug in from the group practice, if you will, and to remind the patient on an hourly or three times a day basis what pills to take when and even to go so far as to check with them for side effects. We're within striking distance of that.

And then what about the research data base, that rich data base of that integrated model of care. That kind of linkage I think will allow us not only to provide more continuity of care to the patient and family, but it will also allow us to even better sharpen our determination of

good quality care, best practice patterns and good outcomes in terms of quality.

In terms of various problems that we see as we move towards that system, yes, indeed, there will be payment reform on the physician side. Over the next two to three years I think you will find moving through the inherent reasonableness stage -- some folks would say inherently unreasonable. But at this point the Department has been charged to look at those particular activities in three areas: cataract surgery, coronary artery bypass surgery and pace makers, and then to move on to a list of ten other procedures to try to limit excess prevailing charges. Eventually I think what you'll see if a limitation on the national average charge system and then a move from that to a relative value scale and, hopefully, then a move through that into a more capitated payment system.

The whole issue of participation/non-participation -- Senator Durenberger has already mentioned it to you and I think it is important to recognize it is a number one agenda item for the elderly in organized groups, such as the AARP. So I would expect you will find continuing attempts to make the differences between participating and non-participating physicians more and more diverse. And as we look into the far future, then, I think we can see that in this 12 years time frame before we reach

the new millenium there will be continued changes going on in the health care system. I hope those continued changes will continue to involve all of you because only by that kind of personal involvement can we shape the system into the future as we need it shaped.

It's obviously true, people have said that the winds of change are blowing. But don't look at just the waves on the surface of the ocean that's been created from these winds, but look rather underneath at the currents beneath the ocean because it is the currents that you need to read as you react and set your course and sail your ship into the future. And if you continue to work in an organization such as this, which is obviously far more able to steer you or to give you the charts to steer you through those currents so that you don't crack up on the shores, I think you will arrive at the new millenium of the year 2000 in charge of your own destiny, although you may think there are some rough waves ahead and indeed there may well be. But the more you work toward integrating your own concepts into the way health policy is delivered, the more successful you will be as you arrive at that new millenium.

So I wish you bon voyage.

(Applause.)

DR. SPOTO: Thank you, Dr. Davis.

I'd like for you all to please hold your

questions until the end of the session. We will have a question and answer session of the panel at the end of the session.

In his leadership role as President and Chief Operating Officer of the Voluntary Hospitals of America, David P. Hunter oversees a 600 hospital national health care delivery system. Established in 1977 to strengthen the voluntary hospital sector, VHA seeks to improve the competitive position of its member institutions by providing system advantages. Prior to joining VHA Mr. Hunter was President of the Nexus Health Care Corporation, the parent company of Memorial Hospital in Burlington County.

It's with great pleasure that I introduce to you VHA President, David P. Hunter.

(Applause.)

MR. HUNTER: Thank you, Angelo.

I appreciate the opportunity to be here with you this morning and talk about some of these issues. I listened with a lot of attention to what Dr. Davis had to say and I hope that what we do with our organization is help physicians and hospitals to make some of that come true earlier, rather than later.

My assignment this morning is to try to give you a feel for what VHA is all about and what we see as our role with respect to the health care industry and with respect to

physicians particularly. I'll try to do that in three ways: One, by reviewing with you some of the data that we use to make our decisions with respect to the operation of our company on. We have a market monitor that we follow pretty closely and it does shape our influence and I thought I'd give you a sample of the kind of information that we look at as we make our decisions, and then I'd tell you just a little bit about VHA to give you a feel for what it is and what we are trying to accomplish with it in terms of the institutions, and then, finally, I'd like to spend a few minutes telling you what our relationship and role will be with the physicians associated with VHA hospitals in the future and what it is now.

As I begin -- I'm going to run through a few slides with you. But as I begin what I'd like to tell you about is that VHA really is committed to the goals that Angelo talked about a minute ago. Our job is to try and make the voluntary hospitals in this country competitive, positioned well in their individual local markets and able to thrive and prosper in the future.

We are, however, some different things in terms of being able to do that. One of the things that we are is a for-profit investor owned company. We are not a not-for-profit organization or association. Many of you probably are aware of us because some of your hospitals I'm sure are

involved with VHA. The crucial difference is that the investors in VHA, in large part, are our hospitals and to a larger extent and to an increasing extent, the physicians that are involved in VHA, and that will become more so in the future.

So that in many respects, as you listen to -- Sam and I talked this morning, we're going to sound perhaps a little bit alike. The differences are who owns us and how we respond, perhaps, and what some of our goals are. But certainly a lot of what we do is similar.

If I could try some slides. Let me start with this slide showing VHA market monitor's data base. What we have is a data base that we regularly look at that includes 1,600 physicians, 4,000 consumers and 1,600 employers. We studied the data bases in waves. To give you a handle on how many physicians we've talked to with respect to this information, we're now up to about 7,000 physicians whose opinions we've solicited with respect to the issues we're concerned about. One of those issues is the ability to identify quality, and you heard a discussion from Sam this morning about the importance of physicians and quality and we certainly believe that.

This slide seems to indicate that the ability to differentiate quality, at least among our test group, is highest among physicians. They are especially good at

differentiating quality between physicians. It seems to -- it seems to us, at any rate, that the lowest ability to differentiate health care is between health plans, and I think that's indicated by a lot of the activity of the health plans today in terms of studying different ways of getting at the quality issue and some of the issues that Dr. Davis was talking about earlier.

One of the things we think is important and we think is important to our physicians and I'm sure many of your groups are engaged in these in one or another is joint ventures. Joint ventures with local hospitals, but also joint ventures with national systems. Our data indicates that physicians have a fairly high and increasing interest in becoming involved with joint ventures and that it doesn't vary radically from age group to age group so that we do believe that a strategy of involving physicians and hospitals as joint providers in joint ventures for health care is an appropriate and adequate one.

The reasons that the physicians seem to want to participate in joint ventures from our data are that they wish to maintain market share. No surprise. They want to provide access to the markets. They want to maintain their practice styles. They'd like to share investment opportunities. They'd like to share financial risks and they certainly want to have a competitive advantage in this

increasingly competitive environment that we're all talking about.

Some of the hospital actions that we think from our data are attractive to physicians and try to -- and guide us in terms of physician bonding and trying to attract the right groups of physicians to our hospitals are of course quality. Secondly, as you would suspect, better facilities and services, and finally, specialized services seem to be those things which physicians are attracted to hospitals most frequently by.

We talk to them a lot about the maintenance of referral patterns. It's a topic that we'll discuss more and more with our physician task forces, and I'll tell you a little bit more about that later. But it seems that across the board physicians are very concerned, and I'm sure all of you involved in group practices are concerned with maintaining your referral patterns.

Because of our joint venture with Aetna, we're very concerned about the interest in physicians in HMO participation and this slide shows you our estimation of the interest in PPO participation by physicians by years of practice. And as you would suspect, the older physicians are less likely to be interested. The younger physicians are more likely to be interested, and across the board interest is pretty high, which indicates that good PPO

plans, it seemed to us, will be well received by physicians both in private and group practice alike.

We're also interested, as I'm sure you are, in what the discounting practices are. We're fascinated that as we listen to physicians on an anecdotal basis, it seems to be a hotter topic than it really is. There are only 2 percent of physicians in our sample that are giving no discounts and we've got 5 percent of physicians giving discounts as high as 20 percent off of their fee schedules and we think that's significant in terms of physicians willingness to participate in providing discounts for PPO's.

Another slide that was really interesting to us predominantly coming out of our hospital backgrounds is the physician's willingness to switch hospitals to save a patient $150 per stay, and you can see that with an interest in saving patients $150 per stay physicians are willing to move -- their patients are willing to move themselves to preferred provider organizations and other kinds of organizational decisions.

We thought that one of the things that was important and interesting to us was employer factors in selecting a health plan, and we thought our physicians would be interested in that. It's important I think that consistent with all the conversation we've heard here today and in other locations that physicians and hospital quality

lead the league in terms of the important employer factors in decisions. My own view of that may be a little more cynical in that I think when an employer selects a health plan the last thing he wants to see is the employer -- the employee back in the health benefit manager's office complaining about the plan the employer selected or participated in and I think that their interest in quality is as a result of having happy employees with respect to the benefits. They are -- at least in our survey group, quality exceed cost, ease of paperwork and comprehensiveness of services in importance.

(End side one, tape one.)

-- joining the specific PPO. The quality of the physicians in hospitals ranked as the most important factors: Who are your colleagues, what hospitals are they associated with. The sponsoring organization and convenience were pretty important as well. Profit participation was less so.

We were interested in asking our physicians who their competitors were and in the sample group that -- we have 31 percent identified other physicians, 25 percent identified HMO's, 5 percent identified urgent care centers and probably the biggest surprise to me is 30 percent didn't know who their competiton was. It seemed to me in this day and age, as bad as it's getting, that would be awful

interesting to anybody. Nine percent of the physicians thought that hospitals were the competition and I know that some people feel that that number isn't quite right.

If we start moving to consumer awareness of hospital systems, a topic that's interesting to us, you can see that the trend runs from an awareness of zero with respect to systems, there's about 43 percent who aren't aware, to one system at 31 percent, two systems at 16 percent and three systems at 10 percent. I think what this does is reflect the fact that there probably is, as we look at this over time, an increasing awareness of consumers at the baseline of grassroots level in national organizations and national systems. So that it might be something that we need to concern ourselves with.

Hospitals and systems, relating again to what we're trying to accomplish, have increased dramatically from 1960 to 1990. We think that that will probably go up on a continuing basis until most of the hospitals in the country have chosen sides in one way shape or form. We think, by the way, largely that's going to be driven by the alternative delivery system strategy.

Market share from our sample data indicates that stand alone hospitals still have a large piece of the market at 41 percent, VHA with about 12 percent of the hospitals, the Catholic Church with 11 and the investor owned with 18.

Other alliances and other not-for-profit systems have about 18 together.

If you look at that -- if you look at that statistic and you look at that same pie chart, by beds you see that the stand alones are 31 percent, VHA is 19 percent, investor owned is 13 percent. VThese numbers change dramatically all the time and it's interesting to us to see what the growth rate in these various systems are.

Our own experience is that it's represented by this slide. We're sitting today at 685 hospitals. We'll be at 700 by the end of the year. In 1988 we expect to add another hundrd, so we'll probably be right around 800. We currently have 184 beds. For your information, we're about 65 percent occupied with 6.5 million admissions and $23 billion of revenues. VThe important statistic on that slide for this audience is that there are 137,000 physicians associated with VHA hospitals. Historically VHA was a hospital service. VThe strategy in VHA, as I'll review with you in a moment, is to really spend a good portion of our activity in the next several years addressing bringing the same kinds of advantages we brought to hospitals to that group of 137,000 physicians associated with VHA. Then we have 13,700 trutees associated with our organizations across the country as well.

VHA in the last 12 months probably engaged in

about a $1.5 billion worth of economic transactions itself on behalf of its hospitals. That gives you an idea of where we think we're going to be by 1990 and we think that with everything that we have -- our share holder hospital, affiliated institutions, contracted institutions, regional health care system hospitals that are involved with us and our diversified facilitis and some of those will be health plans -- we will be at about 1,000 separate organization units or institutions participating in VHA.

VHA's bed growth will probably follow this slide fairly closely as we go through time so that for our hospitals and the physicians associated with us we should be able to have significant enough influence to try and maintain the competitive advantage that we've talked about for the voluntary hospitals.

Our system focuses on four things. The first of these is markets, developmental markets, selection of the hospitals, development of market-oriented, local market oriented and regional market oriented, patient acquisition strategies, image development and the development of markets where we can insure the physicians and hospitals adequately.

A second issue that we focus on is capital and we focus on the issue of debt and equity capital. Right now, in my opinion, the hysteria rampant in the land is in alternative delivery systems and managed care organizations

and everything else, and all your hospital CEO's and you, as well, are concerned with that and it's the hottest topic at any health care meeting that I've been to in the last year.

If we look at our crystal ball, the worst problem facing the health care industry, particularly on the not for profit side, in the next five years is going to be able to develop the capital to continuously retool and maintain the competitive edge with respect to the acquisition and technology and other kinds of services.

We focus on management. Our focus on management is to try and provide services and activities that can make those hospitals competitive through providing them with strategically important information, education, resources and programs that would save them money. An example of that is the VHA Supply Company, an organizational component that saves our hospitals up to about 13 percent on purchases a year. We're currently acquiring about $750 million worth of products for our hospitals. We will probably exceed $1 billion in acquisition next year and next year we intend to open a physician purchasing program for those 137,000 physicians associated with VHA.

And then finally we focus on physician alliances, and the physician alliance peace is to develop linkages with our physicians that are important to the physicians and will provide them with some specific strategic advantages in

their own right. We need to get physicians to do things for their hospitals, as you can appreciate. The partnership is more important than it's ever been between hospitals and physicians, and, secondly, we need to do things for those physicians to position them in their own marketplaces.

That's the end of my slides, if you want to turn the lights up a little bit.

Let me tell you quickly about four or five things that we are working on with respect to developing the physician linkage strategy at VHA. First of all, partners -- our national health plan joint venture with Aetna is designed around products that will provide physicians as well as hospitals with patient acquisition opportunities, competitive positioning and an opportunity to participate in the risks and the profit. The partnership with Aetna is a good and solid partnership and we're pleased with it to date. We've worked at it. We've tinkered at it. We've reorganized and we have come to a point where we think it's really beginning to go very, very well and all of us have recommitted some additional capital to that program to make sure that it does well and provides advantage to our hospitals and our physicians.

Another things that we're doing is we're developing and we'll inaugurate in 1987 a practice management company to provide advantages and services to the

physicians and the groups who are associated with the VHA hospitals in areas like business plan development, evaluation of practice purchases, the improvement in credit collections and reductions in accounts receivable, feasibility studies for adding partners or expansion of groups, business office procedure and protocol development kinds of activities.

We will add to that in 1987 for the phsycians associated with VHA hospitals opportunities, as I mentioned earlier, to access products at lower than average market prices because we'll be able to do that because of the number of physicians we can represent and the size of the systems leveraging in acquisition of products.

We will also, and I shudder to say this, but it has been identified in our group as one of the most important things that we can do in 1987, is we will also introduce a physician malpractice insurance product and it will be for those physicians associated with VHA hospitals and characteristically enough, as you all know, I'm sure, and are all aware, it's going to be easier for us to do that to the extent that we're dealing with group practices. As you probably know better than I, it's easier to get group practices insured today than it is to get individual physicians insured.

We encourage and will encourage on an increasing

basis the development of physician-hospital joint ventures, both at the local, regional and potentially at the national level. And then, finally, in a couple of other areas, we encourage physician ownership in VHA. Physicians are owners in VHA at this juncture and will become increasingly so over the year in 1987.

Much has been made of the quality issue. It's an important issue. It's a strategically important issue for us as it is for anybody else working in this industry and in 1986 and 87 we have developed a position with respect to quality in VHA. We've developed it jointly with our physicians and will begin to deal with the quality issue as it affects VHA's position in the market place, as Dr. Davis indicated, in 1987 and the physicians are of course going to be an integral part of that. The one thing that I agree with Dr. Samons about is that you can't do that job without heavy, heavy physician involvement and we won't make the mistake of not doing that.

Finally, the way in which we integrate our physicians -- as you can imagine it's a rather amorphous, large structure out there -- is through two significant task forces. One task force evaluating products and programs from the point of view of physicians that VHA is developing and has developed, and then another one designed of looking at VHA's relationship to its physicians. How should they

input -- provide their own input into this big organization? What can it do for them? What can they do for the organization? What should be the relationship to all kinds of delicate things, like referrals for example. One of the things that I'm fond of saying is that VHA would not need to go in the HMO/PPO business in any way shape or form if we could just get these physicians to internalize their referrals. Itwould be a bigger patient acquisition strategy than any joint venture with an insurance company.

We just did a little bit of study and we found out that a majority of the referrals for transplantation in VHA go outside the VHA system for a whole variety of reasons. Our physician task force is looking at that kind of an issue. How do we deal with tha? Is there a way we can affect it? Is there a way we can take a look at that kind of an issue?

They're dealing with centers of excellence in the development of VHA programs in that regard and they're dealing with how do you clinically franchise certain programs across the country that have been particularly effective in one VHA hospital or another while providing recognition and return to the originating hospital and the originating group of physicians.

All of that kind of activity is going on within VHA at this juncture with respect to our positions and

basically we will spend a good deal of our time trying to develop and nurture relationships with those physicians over the next couple of years.

Angelo, thank you very much.

(Applause.)

DR. SPOTO: Thank you, David.

Samuel W. Owen, II assumed his current position as President of the HCA Physicians Services Company, a Nashville, Tennessee based health care management company, in 1985. A member of the American College of Health Care Executive, Mr. Owen previously served in hospital adminstrative positions at Miami, Florida's Baptist Hospital and Hillcrest Medical Center in Tulsa, Oklahoma.

Let's give a warm welcome to Samuel W. Owen, II.

(Applause.)

DR. OWEN: Thank you, Angelo. I appreciate that introduction. And, Carol, I, too, need glasses. Regulations had nothing to do with it, but it did have something to do with my receding hairline and the graying of my temples.

(Laughter.)

Davis is correct. I anticipated that he would say many things that would be familiar to me from HCA's point of view. Therefore, I'm taking a little bit different approach in my remarks this morning, and I want to tell you

about HCA.

I want to thank you before I do that, though, for allowing HCA and the Federation of American Health Systems for being a part of your conference and it's truly a privilege for me to be here personally. One of my best friends, whom many of you know, David Williamson, would have loved to have been here with this group today, and I'm going to do my best to uphold his tradition. As many of you know, Dave passed away a few weeks ago and it's saddened many of us.

It's also great to see many of my old friends here. People from Lewis Gale Clinic where I had a very fine association for many years, the Medical Center at Pensacola, the Harbin Clinic down in Rome, Georiga and Carl Clinic and many others.

During the past couple of weeks, since being asked to be a part of this conference and to address this group, I frequently wondered how to respond to the theme of our portion of your conference. Health systems perspectives. Nashville, Tennessee being my hometown and known as Music City, U.S.A. has an abundance of country music radio stations that one must listen to from time to time, whether you want to or not, and recently I heard some country songs whose titles caught my ear and I have a reason for sharing them with you.

These titles are great. They're descriptive and they're humorous. Let me share them with you. The first one is My Wife Ran Off with My Best Friend and Oh How I Miss Him.

(Laughter.)

The second is, He Was Trying to Score So She Threw Him Out at Home.

(Laughter.)

And third, It Wouldn't Be So Bad If It Hadn't Been So Good.

And you are probably wondering what song titles have to do with my remarks to you today and with your conference. Well, these song titles gave me a bright idea. Come up with a catchy title, build your comments around it, be short and descriptive and to the point. But I decided to take this one step further by looking at the situation through the practicing physician's eyes rather than those of the larger provider system.

Now you're going to have to use your imagination here. I want you to let it run free and get the scene. High above the super meds are circling doctors awaiting to pounce upon them. There is a fear among you of losing control of your business, your practice, but most of all quality of care. You're confused about the future and some even predict that you will be employed by the super meds or

other corporate giants. Choices, choices, choices. Who do you want to be our partner.

This list could go on and on, but my title will depict the situation in which the difference between your size and our size may make us appear unapproachable or unaffected by what's going on around us, especially if you don't know us. So, hence, my remarks are entitled It's Hard To Say I Love You From Way Down Here.

(Laughter.)

Now I want to share one company's perspective. It's the only one that I know extremely well. It's not a prediction nor a forecast. It's not a prognostication. It's a belief. It's a belief that's as old as HCA itself, and it's the foundation upon which the founders of our company, Doctors Thomas F. Frish, Senior and Junior, built this company of HCA. It's that belief that very simple, and that is that doctors are our partners and they always have been. Their involvement and input is essential to our company if it's to succeed and become a great American business enterprise.

Our mission statement expresses it very well, I think, and it adorns every wall of every hospital in our company and every office. This mission statement says:

"HCA is in the business to attain international leadership in the health care field, to provide excellence

in the health care and to improve the standards of health care in the communities in which we operate. To provide superior facilities and needed services to enable you, the physician, to best serve the needs of your patient, and of course to generate measureable benefits for the company, for the medical staff, the employee, the investor, but most importantly the patient."

Now, let me share with you some views in my own language and hopefully it will give a clear and concise understanding about how HCA will move into the future. Upon finishing, I may even attempt to create a new title for my remarks. Needless to say, quality of care and patient service is the objective of each of us in this room. If it's not, we're not deserving of the privilege to work in the most exciting and fulfilling industry in the world.

One of our founders, Dr. Frish, Senior, has a espoused from the first day that HCA was conceived, that if quality is the foremost objective of our company all other benefits will come automatically. We all know that quality is difficult to define, but it's achieved by demanding excellence of oneself and giving excellence to others. It's the aligning with the best physicians and other health professionals in providing the means for them to succeed.

So, before we go further, let's establish the fact that quality is the benchmark from which we will work.

This business we are in, it's a people business. People are our greatest asset. People deliver our product, patient care. So we must set the tone for all of our associates to be committed to excellence. If we do, we'll succeed regardless of the course our business finally takes. And one thing is for sure, our business is changing.

We're likely to continue to have a surplus of hospital beds and in many areas there is going to be a surplus of physicians. All of you have seen the statistics predicting the growth of the number of doctors who will be competing for patients by the year 2,000. But this just means all of us will have to continue to re-examine and re-assess our thinking on the ways that we do business. But before we act out of fear, we need to take comfort in knowing that health care is still a $400 billion industry and growing. So if all of us provide society with the quality services and make a reasonabel return on our services rendered we will retain the public's trust.

However, if we do not act responsibly and do not deliver quality of care we will loose society's trust and deservedly so. Quality equals business. Quality is truly a bottom line concern.

The second major point is that relationships with physicians in HCA are built upon trust. We of HCA have made a commitment from the day we started, and before even, to

build strong and enduring relationships with the doctors and today I'm here to reaffirm that commitment. The physicians provide direct advice to the senior management of our company by serving on our board of governors whose membership is comprised totally of physicians. Physicians provide direct input on HCA's corporate policy by serving on our corporate board of directors, and every hospital we own has a local board of trustees where to my knowledge physicians represent a majority of the members.

Now, my purpose in reviewing this is to demonstrate the importance of physician input and trust and the decision making process at all levels within HCA. This commitment to physician partners has made HCA the physician oriented health care company it is today. This foundation was not built upon the premise that HCA controlled doctors or vice versa, but in fact that we work together in mutual harmony. In fact, if you get no other message today, I want each of you to know that we do not view physicians as competitors or as adversaries. We view you as our partner.

This trust relationship exists because we've always been partners in care and we pledged on the cover of our latest annual report -- that's the 1985 annual report -- this will not change. But I want to assure you we're not satisfied with the status quo. We constantly evalute ourselves and we look for new and innovative ways to enhance

and strengthen our relationships with physicians. A clear signal of the high value we place upon our physician relations was the creation of the physician services company. The sole purpose of this organization, of which I'm President, is to monitor and continually make certain that our physician relationships are premier in the industry.

This brings me to my third point. Our business, in our judgment, is for now and the foreseeable future a local business. Oh, there are some national and regional applications, of course, but in the main they are not dominant. Our experience has proven that each place is different. Each hospital in the community it serves has its own mores, customs and characteristics. Meeting such needs cannot be dictated from remote management. Local input and guidance is absolutely essential. But don't misunderstand me. There are benefits, obviously, of being associated wtih an organization such as HCA, through the common scales and other avenues. These benefits are available not only to our local hospitals, but to our physicians who work with us at our hospitals.

But these relate to the cost side of the equation. On the customer side of the equation, that's physicians and patients in our jargon, it's a totally different matter. Decisions must be made at the local or

grassroots level. Each of our hospital administrators has an obligation to be innovative and decisive and operate according to local needs. This can only be done and accomplished in partnership with doctors at the local level. At this level, bigger is not necessarily better. Better is better. And that's what we want to be, is better.

These commitments do not imply nor suggest that we will not be cognizant of regional and national trends in the organization and delivery of health care services. I can assure you, though, that any response to these trends will be done in consert with our physician partners.

In summary, let me refer to recent remarks made by Mr. Alex McMahon, who is the former President of the American Hospital Association and currently serves as Chairman of Duke University's Health Administration Program, a part of their school of medicine. Alex questioned certain myths about our industry and it's future direction when he spoke at the Annual Meeting of the American College of Surgeons in just the past few months. Among those myths Alex questoned are these.

Myth, a handful of super meds. Folks like the VHA, HCA and others will control the entire health care system by 1990. The truth is health care is a local business, regional at best, as we can see it right now. There is no such thing as a super med. HCA does not want to

control you. We want to be your partner.

Another myth. Most physicians will be employees or working for big corporate giants by 1990. The truth is we at HCA believe that physicians work best when they work for themselves. We do not want to control you. We want to be your partner.

Myth, HMO's, as we know them today, will dominate the health care industry by 1990. The truth is multiple forms of delivery will exist and competitive payment systems will emerge. But don't forget fee for service is not dead yet. Regardless of the form of payment or delivery, it must provide quality or it will fail. We want to work with doctors to find innovations, to respond to change. We want to be your partner.

So we at HCA tend to agree with Alex McMahon that these in fact are myths. We think future plans should be based on the reality of our business, which I've touched upon today, but let me remind you of the key points.

There must be total commitment to quality. Quality is a bottom line concern. Winners have it; losers don't. Relationships with doctors must be built upon trust, not deceit not control, and health care is a local business. It's personal. And finally, HCA has never and will try to control physicians. We want to work with you to make the best health care system better. We want to be your partner,

which brings me back to the issue of deciding upon a title for my remarks.

Perhaps the most fitting title, after hearing my comments about trust and partnership, could be drawn from the song made popular by Anne Murray, known affectionately as the Canadian songbird, when she sings Could We Have This Dance For The Rest of Our Lives.

(Laughter.)

(Applause.)

DR. SPOTO: As Vice President of Health Programs Development for Blue Cross of Massachusetts, Jacob Getson is responsible for managing the HMO line of business and for establishing comprehensive health systems, principally HMO's that link health care financing and delivery.

For eight years prior to coming to Blue Cross of Massachusetts he was the Assistant Secretary for Health and Human Services of the Commonwealth of Massachusetts and has also been Assistant Commissioner of the Massachusetts Department of Public Health and Executive Director of the Office of State Health Planning. His many professional and community affiliations include being Executive Vice President and Treasurer of the Falon Community Health Plan, serving on the Governor's Alliance Against Drugs and membership on the Board of Directors of the North Shore Health Plan.

Please welcome Jacob Getson.

(Applause.)

MR. GETSON: It is a pleasure for me to be here as well. My claim to fame, besides what my office sent over to the Practice for the announcement, that I'm proud of is that I played football at Temple University. Now, the good news is that I was the tackle who played in front of Bill Cosby, who played half back at that point in time. The bad news for me was that we lost 21 straight football games when I played --

(Laughter.)

-- and so I learned to look for very small victories in my footback career, and in the eight years that I was in State Government and in the eight years that I've been at Blue Cross and Blue Shield I've looked for very small victories as well in terms of both survival and impact.

At the end of my football career, although battered, I an still able to walk off the field with a little bit of pride for my participation, and in the State Government, during a very turbulent period of time of cost containment efforts through the Seventies, I feel the same way. And through eight years of building HMO relationships in the Commonwealth of Massachusetts with physicians I feel even more the same.

I think the title of the song that I would put forward, If It Sounds So Good Why Does It Feel So Bad, and I think that the --

(Laughter.)

I think that the problem that all of us have faced over the last 20 years of change and turmoil is really that, is how to get underneath all of the rhetoric that we're talking about, all the labels and all the definitions and really sort them out. Who are we? What do we stand for? What are the values in the system that we stand for? What business -- what the hell business are we in? What is the business? Who is driving the ship of state that we're all on and what voice do each of us have?

And I represent at this point in time Blue Cross and Blue Shield and Blue Cross, and Blue Shield has gone through the turmoils of change and will go through as well what all of us will go through over the next few years. I want to talk just a little bit in terms of background of what's happened here in the last 15 or 20 years. What I mean by the difference between the rhetoric and the reality of what's been happening. A little bit of what I think -- trying to meld all of what I heard and what you heard into at least my own perceptions of the future so that you could walk out of this room able to make better choices for yourself.

Now, the only thing worse than being the last speaker before lunch is being the last speaker before a cocktail party and at least it's only the lunch we have to look forward to. So I'll try to be pretty quick about it.

In the Sixties, Seventies and Eighties in terms of public policy rhetoric we talked a fairly good game, in the Sixties, about access to health care. Public policy at the government level, at the federal and state level, really tried to create an attitude that all people should have access to a single quality health care system. We poured a lot of federal money and state money in support of building hospitals, building medical schools and nursing schools and training of health care professionals. We stimulated research and we tried to stimulate the health care industry to respond, to open up and grow so that all people in the United States could have access to health care, high quality health care, and that was in fact rhetoric of public policy.

I think during the Sixties, with the advent of Medicare and Medicaid, with the advent of all of the funding sources, a poured a tremendous amount of dollars into the public sector to stimulate the private sector economy to grow and I think that that in fact happened. Nobody thought through the impact of all of that, and so half way into that growth everybody realized that there was no real way to fund the system that was coming on line.

So the Seventies turned into a high public policy approach at regulations. Very interesting in terms of the impact of that in that we talked a great game of cost containment, but I don't think we had very little impact on that at all. And I'll just tell you one or two numbers to put it in perspective at a local level.

I worked for three governors in the State of Massachusetts. I was originally hired by a liberal Republican. I stayed through the first Dukakis Administration; the first two years of Governor King. Three very different governors. All of them really panicked about the high health care cost drain on the State budget and on the State economy. And I'll just use this example.

One of the principal measures of health care expenditures in the State, in any state, is the Medicaid budget, which represents a 50 percent funding of state funds and a 50 percent funding of federal funds to pay for the health care needs of the indigent population in this Commonwealth. In the eight-year period of time that I was in the State Government responsible for cost containment, the State's participation in Medicaid went from $350 million to $1.2 billion. A phenomenal amount of money pouring out. Very little -- as a matter of fact, a reduction in benefits over that period of time and really nobody would claim that the health care consumers in the Medicaid population had

full access to the highest quality care.

Not only couldn't we control the cost of the Medicaid budget, we couldn't even define it during the majority of the time that I was in government. We didn't know where the money was going. It was going out in a way that in fact worked against cost containment efforts and so there was a tremendous amount of frustration, and in fact a panic, I would say, in terms of trying to control the cost on the Medicaid saide.

The regulatory apparatus of certificate of need, rate review, PSRO, Blue Shield usual customery -- all of the devices really were flawed, and three basic reasons. I want to highlight them because I think that in terms of what's happening in terms of the changes in the future, those flaws are what have been changing to really indicate what will happen in the future.

The first flaw is that we paid for the units of service in the health care system in a fee for service manner, and in fact all of the incentives that are inherent in a fee for service payment mechanism are in fact inflationary. If you pay by piece work and if you can strain the price of pieces, then the volume is going to increase. It's human nature. It's the natural order of things.

In fact, in tracing back over the history of

payment in the health care field I think that we can all see, as the frustration and the illogic of the payment mechanism in the hands of the providers -- both institutional and professional -- became apparent, as the government tried to compress the price of goods the utilization and units of service went up, or the measures got smaller in terms of defining the units. So instead of a per diem we pay a per diem plus professional charges, plus laboratory, plus X-ray, plus pharmacy, plus, plus, plus, plus. So the method of payment, from my perspective, the logic doesn't hold up.

The second part of the problem is that we defined our health care system and treated as fragment sections of health care delivery long care, chronic care, mental health care, acute care, ambulatory care, primary care, all of them with narrow channels of payment unrelated in terms of their central source or direction. And in fact, you push or compress a unit beyond the normal and it comes up in some other place. You don't allow nursing home beds. You have administratively necessary days. You create a public policy for ambulatory surgery but don't compress down the institutional payments and you have added costs.

So, the fee for service, payment mechanism, the fragmentation of the delivery system in its definition, and the third is the separation between insurance or payment and

provision of health care created a level of tension and polarization that really does not and has not and for a while will not create the feeling of real partnership, real pulling together, a real sense of direction, an agreement to the mission, to the value system. It exists because we've gone through 25 years of mixed messages of incentives. We have different missions in the polarization and there's a lot of debate as to what value and what business are we talking about.

In the insurance industry, the way it was originally designed in terms of a creation of a benefit package that was sold to employers as an intermediary, it really had the insurance vehicle as somewhat neutral in terms of the provision of health care. It treated all providers as equal, and really the question of a good insurance program was how comprehensive were the benefits, how quick could you make the payment and accurately can you make the payment and where could you price this thing. And quite frankly in insurance, in the same way -- in the providers of health care, the notion was how to pass through your cost on to somebody else. The issue of risk, the issue of management, the issue of defining reasonableness, of balancing was not in the system and to the most part is just now beginning to come into the system that we all are living in.

But that has changed, and really it changed about seven or eight years ago and some people still don't know it's changed and some people are hoping that the change will go away. I feel that the trends that are in place are trends that will be pervasive and will really control the direction of the next seven or eight or nine years in a dramatic way. I will try to talk about that a little bit in a very short period of time, but I think you'll get the feeling and the direction.

Why have HMO's been so successful? Well, they've been successful because inherently in their organization they have -- in the best organized HMO's they tend to deal with all of the issues that I defined as the major problems and why the system has not functioned in the way it should from my perspective, and that is, an HMO is the mixture of insurance and the provision of health care.

An HMO is comprehensive in nature and has inherently in its delivery system a full range of total services to serve a community. It has built into it a payment mechanism that puts all of the insurers, the providers and in fact the subscribers on the same incentive system, or should. In fact it's balanced and if it's organized right, it's community based at its local level and attached to the community in which the provision of care is given. Now, that's not all HMO's. That's some. The ones

that are doing the best I think are the ones that are organized in that fashion. You can take the label off of it. You can take the name away from it, and in fact that logic works tremendously well.

I want to give you just a couple of numbers to put it in perspective.

I Massachusetts traditional insurance -- in 1980 traditional insurance was buying for its under-65 population in the State of Masschusetts 700 hospital days per thousand. The average premium on a family of four in a Blue Cross Blue Shield comprehensive major medical was around $2,500 a year and it represented fundamentally the payment of those 700 hospital days.

The HMO's which are organized in this state -- and at this point in time there are a million Massachusetts residents out of six enrolled -- about 17 percent of the State's population are now in HMO -- are averaging -- well, at that point in time, in 1980 when it was 700 days per thousands in the traditional insurance, the HMO's were around 450 days per thousand. This is age and sex adjusted, basically the same populations. Roughly the difference between 450 and 700 days per thousand. That difference in its organization can fund a lot of primary care, a lot of ambulatory benefits, a reduction in premium. As a matter of fact, the premium for an HMO at that period of time against

a $250 a month premium was around $180. A significant difference.

It's even more dramatic in looking at the over 65 population, we have in this State -- Medicare around 1980 actually was buying 4,500 hospital days per thousand for its 750,000 elderly in Massachusetts. A tremendous burden in terms of the expenditure of health care costs on the Medicare budget at the federal level.

The HMO's that we had with Medicare risk contracts in and around the 1980-82, at that point in time, found health plan being the predominant risk experiment. The first in the United States. One of the first group of four. The days per thousand were around 2,000 at that point in time against the 4,500 day level.

We now have in the State of Massachusetts in Blue Cross Blue Shield HMO's about 30,000 Medicare enrolees in six plans across the State and we're averaging about 2,200 days per thousand in an age adjusted population with the medical population. Tremendous savings and a tremendous efficiency.

So, the HMO's in themselves, not because they're HMO's but because they have the principal to bringing the providers both hospital and physician and insurance companies on the same risk and incentive program, have the ability to work at a more efficient level and in fact, I

think, a more logical and better health care delivery system.

What is the right balance? What is the protection for quality? How can you insure that an HMO doesn't skim just the young and healthy? How do you assure that the needed provisions are given? The ethics are not in the reimbursement system. The ethics are in the providers of care, no matter what the reimbursement system. So the point in terms of the value system that drives the group practice or drives an individual physician or drives an insurance company is what has to be understood and put into place.

The reimbursement system has in it incentives. The incentives are fee for service or more volume and more intensity. The incentives of capitation and in fact DRG's are the limitation of resources. What's the right balance? What's the gray areas? What's the levels of decisions in terms of where you draw the line and who's going to draw that line are really the questions of the future.

The issues of control is not control of the indivdiual physician by salary or by contract or by affiliation. It is how and who will shape the values of the health systems that will form. Will they be driven on price alone? Will they be driven on service alone? Will they be driven on the balance of those things?

There are a couple of major changes coming and I want to just highlight them before I close.

The first is -- I think that one of the major shifts that will happen and is starting to happen already is in fact the selectivity of providers versus the blanket inclusion of all providers under systems. More and more accounts, businesses, governmental agencies are starting to look to differentiate on performance in the provider community. We're seeing it in terms of what businesses are demanding of us as an insurance company in the same areas. The price difference between Gillette in this area is an account of ours, of the State employees as an account is the age and sex and utilization of their employees, but it's also which providers do they choose to use in a freedom of choice product.

When I started at Blue Cross and Blue Shield in 1980 we predicted at that point, which was innovative at the time, that the managed cared and HMO systems weren't going to be 10 percent of the State's population by 1990 but would be 30 percent of the State's population. We always felt that freedom of choice would represent 70 percent of the choice and selected choice or managed care would represent about 30. That was a major change from the 90-10 that we were working on at that point -- up until that point in time.

Well, the predictions have changed. We're already at 17 percent. Our guess is that not only will we reach the 30 to 40 percent in terms of HMO's, but the 60 percent on the other side of it, the 70 percent will change dramatically. What we're saying now is 10 percent of our business in 1990 will be in freedom of choice products. 90 percent will be in selected choice products mixed between HMO's at the 40 percent level and another -- better make sure my numbers are right. Another 45 percent in PPO or managed care and PPO-type project selected products, with only about 10 percent of our population in the traditional freedom of choice providers products, and they will be the people who can afford it at that higher level.

The majority of people by price and value will start to narrow the choice of employees down by using data analysis, by using reports of analysis of both cost and quality and there will be a tremendous differentiating. And as a matter of fact, in the public's eye I believe selective contracting will be viewed as high quality as opposed to freedom of choice being viewed as high quality now because the consumer will be much more aware of the factors of efficiency and quality over time.

It's like if you think back to the personal computer industry of seven or eight years ago. All these things looked alike, you know. They all had little screens.

They all had little key boards. They had nice little boxes. One cost $800 and one cost $4,000 and the consumer was tremendously confused. There was multiple products. There were 50 new entries. Everybody was rushing into the market place with a personal computer and we bought them for our kids because somebody said it was going to be good to make our family a little smarter and be able to get into a little better college or whatever.

And then we found that some only ran computer games and some could do much more, and we really didn't know what we wanted to do with it as families and as consumers, but we knew it was good so we had one. It wasn't, I don't think, who got into that computer industry in the personal computer level that's important. It's a question of who has remained and who will survive.

And I think in terms of all the change that we're talking about and we've gone through, in terms of national change, HMO's, PPO's, EPO's, IPO's, up your nose, or whatever --

(Laughter.)

-- whatever the new catch phrase really is, it's not who is going to enter into this market and it's not who have gone in first, but at who is going to have the staying power and the capacity to survive over the next four or five years. There is going to be a tremendous consolidation and

a selectivity and a weaning out of the mediocre and the uncommitted. We are going to see a retrenchment as the profit margins of quick and easy dollar rewards retreat.

The price of health care and the profitability is going to contract, not expand. The margins are going to get tighter. We're going to have to improve, all of us, in terms of the way we do our business and how we organize and who we organize to do business with to evolve as the winners in this system.

Like any product, the health care industry has moved into the product environment, away from the public utility model. It will be the ones who will survive are the ones who are going to be organized, who are going to be able to withstand the pressures of all of the external pulls and tugs and it's really -- from my perspective, what it really boils down to is a question of leadership. It's a leadership at an individual doctor level. It's a leadership issue at a group, in my own insurance company, in the community. Who is going to seize the definition of the future? Who will be able to organize it? Who will be able to lead the movement from what has been a fragmented and polarized environment into one that has developed a direction.

Temple University is now a major football power that has a Heisman Throphy winner. Somebody took our little

band of 21 losses into a major change. If that can be done, anything can be done.

(Laughter.)

Thank you very much.

(Applause.)

DR. SPOTO: Thank you, Mr. Getson.

We are now -- the panel is now open to receive your questions. I would request that you go to one of the microphones. This session is being recorded and we would like to have your question on the record. If there is any doubt, I will repeat the question.

Please try to -- should you wish to designate it to a particular panel member.

VOICE: This is a question for Mr. Hunter regarding quality.

Mr. Owen mentioned that quality assurance in his program would be on a local basis, that there were no known national or regional programs. He didn't say that specifically, but I believe that was the summation. Will the VHA quality program be a national program, a regional program or a local program?

MR. HUNTER: As I was sitting here just a minute ago, I turned to Sam and commented on the similarity of the two programs.

The answer is, it is a locally-oriented program.

What we wish to do is to take what we believe to be very high quality hospitals and very high quality medical staffs already in the VHA system and demonstrate to the market place, to government, to consumers that they are in fact high quality and that's provable. You can do that by aggregating their performance and demonstrating the quality of these local institutions nationally. We won't seek to control their quality and we won't seek to make the instutional interpretation or provide rules and regulations. But we will seek to explain how good they really are, and that's what the VHA quality program is all about.

DR. SPOTO: Thank you. I would encourage more questions. Please identify yourself, too.

MR. RANDALL: David Randall, from the Riverside Medical Clinic, Riverside, California.

I'd like to ask either Mr. Hunter or both Mr. Hunter and Mr. Owen how they feel about the pros and cons of a group practice joining with their partnerships in joint venturing versus going public for the same benefits possibly to the group.

DR. SPOTO: Will you repeat the question one more time.

MR. RANDALL: The pros and cons of joint venturing with either of their organizations versus going public on your own, perhaps in conjunction with a hospital.

In other words, I'm asking them to talk about going public and what are the pitfalls and why do they think what they have to offer is better.

DR. SPOTO: We'll ask both of them.

VOICE: I don't know a song title for that answer. But I'll tell you, the way we view it is what Dave just said. It is a local business and it's up to the wishes of the group. If we have a group of physicians that wish to joint venture or do some business with us, we're happy to do that. If it's best for that group to go on its own and do that, then that's the course they should pursue. We are willing and open to working with doctors to work -- to create appropriate business relationships and I think that's a very critical point, one that's appropriate, because there are going to be ethical questions about joint ventures at some point in time.

I think Senator Durenberger said that this morning. So, we move into joint venturing cautiously. We have some, but again, that's up to the local organization and the local physicians and you have to go in that direction. It's what your customer wants; that's what you give him.

Did that reply to your question, I hope. If you want me to clarify I will?

MR. RANDALL: That's fine. Thank you.

VOICE: Your welcome.

DR. ROSENBLOOM: My name is Dr. Rosenbloom. I'm from the North Suburban Clinic in Hoffman Estates.

I was wondering if you could provide me with the information that I don't -- isn't quite clear on how it is being done or will be done in the areas of reimbursement or premiums to include the health status of the patient. In other words, the hypertensive, over weight, smoking patient who does not take our advice to stop these habits. How -- should we be reimbursed higher for them or should they have higher premiumes because of their health status?

VOICE: I think that's a gray area.

VOICE: Two out of three. I don't smoke.

(Laughter.)

Big is beautiful.

I think that the issue of any insured population, and I think this is the issue of risk that we were talking about -- in terms of -- when you begin to mix insurance and the provision of health care and the notion of risk management for a community, the notion of capitation payment is in fact the ability to take a broad amount of population and bring them in against a community rating system. If you're on an experience rating or a cost plus kind of insurance, then you really have to be careful what type of provider reimbursement that you're in. And I want to

differentiate between these two because they all fall under the definition of insurance.

The majority of big groups have bought insurance which has changed dramatically over the last ten years. Companies used to buy insurance, health insurance which the insurance company took the risk of the population, and the actuaries did work to statistically predict the amount of disease against a broad population and there -- (end tape 2, side 1)

-- plus where the company takes the risk and the insurance company provides administrative services, and for an administrative fee, the basic profitability to the insurance company is only in that administrative fee of processing claims. It's the company which actually takes the risk.

In an HMO, the HMO takes the risk for its community. If you are a provider and you're dealing with PPO's or HMO's or traditional insurance, the type of reimbursement and the way you get reimbursed will really differentiate depending on the mix of that kind of businness as a health care provider you take.

My own view is the only good PPO is an HMO and I think that that's an important part because I think that when you get into price discounting and you're dealing with the margin of profitability purely on price you get into all

of the wrong incentives in terms of the old fee for service system. It's a short term relief. It actually doesn't have the long term practice pattern change which has to come about.

A short answer to your specific question is that I think that as the data base gets better you can provide more benefits and more incentives to make the consumer more aware of the price difference and that should be a factor, the participation in terms of whether I get more benefits or have to pay a higher price because I'm a touch over weight. I think it should be a factor and that might help motivate me.

But the real question is, does the health plan or the practice -- I shouldn't even say the health plan, but does the practice have the right incentives to make sure that there is more than just a passive advice going on, but a more interactive system to provide the information in terms of what the real health risks are and how it's managed.

And I want to ask the gentlemen who asked the first question why he only asked those two guys about joint venture. What about Blue Cross and Blue Shield who is out everywhere.

VOICE: I would love to hear your answer.

(Laughter.)

VOICE: Well, my answer is that it's real tough to change what has been an adversarial relationship that has built up over the years because of what I say, the polarization between the insurance function and the providers. But I do believe that the system of the future is one of partnership and business relationships and joint ventures, so to speak. The question of how they're balanced has antitrust concerns and ethical concerns.

But I do believe there will be a real differentiation in Blue Cross and Blue Shield's relationships with providers across the states and particularly in Massachusetts. We will not do the same business with all providers. If you take my prediction of having 10 percent in freedom of choice and 90 percent in selective choice, we will be in selective contracting both with hospitals and doctors and in fact more stable in different business relationships. And I would predict that virtually every Blue Cross and Blue Shield, in order to survive the competitive environment, will have to do the same.

So I think it is the wave of the future. Thank you.

DR. SPOTO: I'm going to ask Dr. Davis to participate in that answer, as well.

DR. DAVIS: Well, let me address the issue of the

health status indicators.

The Health Care Finance Administration has given out a couple of grants and the material is being collected now relative to incidence of certain disorders, sex and some of the other characteristics, that they think would believably change and fine tune the capitation issue itself. I think that's important for them to do and you probably will see those changes coming in about three year's time I would think because it's in the very beginning of the data collection. But as more and more of the data flows in, then the actuaries and the others who are working on that problem will have the material they need to fine tune it.

But keep in mind that as they adjust and raise the percent on those that are so-called using more services or those that the health status indicators would indicate need to have more dollars there, there will be a concomitent move to reduce the 95 percent on the others. So that's the kind of fine tuning that I see will happen.

I can't resist making one comment here. You'll forgive me, but being formerly from the government. I notice I was the only one that nobody asked anything about doing joint ventures with.

(Laughter.)

I suspect is has something to do with the similar phrase as, you know, I'll respect you in the morning.

(Laughter.)

(Applause.)

DR. SPOTO: Next question.

DR. BECKETT: My name is Dr. Jim Beckett. I'm the Medical Director from the Santa Cruz Medical Clinic.

I'm intrigued and would like to understand a little bit better the whole development of the indices that are I guess termed severity index, outcome index. This obviously is a very sensitive area. I think it has profound implications in terms of hospital staffs. I think it has profound implications in relationship to our groups.

And the questions that I have, if physicians and their indices are being developed, numbe one, I'd like to know the availability of those indices for future planning in terms of our groups; number two, given those kinds of dynamics, I would presume that there is some question regarding the viability of so-called, the gate keeping which is generally the primary care doctor. Maybe I'm wrong, but I would think that those indices would favor specialists if you're doing this on a diagnosis per diagnosis basis. And I presume if these are going to be applied or contracting will occur with those physicians who do the best service and take care of the most severe cases, we may actually have a new anacronysm, physician unemployment.

And I would sort of like to hear comments

regarding those questions.

DR. DAVIS: Yes, the work was started several years ago related to the severity of illness indexes and the winter issue of the Health Care Finance Review of 1985 contains a first level description of all of those programs. Susan Horn's work in terms of her classification methodology. She's at Hopkins. VThe work by Wanda Young and the patient classification system. The Apache system and the Medis Group System developed by Brewster and others, and the Disease Staging System by Gunnella.

All of those were the ones that were funded by HCVA and, more recently, the research grant that was given about three years ago -- two and a half, I guess -- to the University of Michigan was to take the initial data that had come from all five of those systems and to draw a sample from CPHA of about -- I think it was 500 and some discharges and then run that indicator as against if you were going to pay with the DRG and one of those is the indicator -- but it's the same data base set -- and see which one had the most predictability and reliability.

That report was turned in and the verbal report was discussed with HCVA yesterday. It will soon be public. I'm sorry I can't give it to you yet in public forum, but I know that it will be out in a future issue of the Health Care Review and it will be being reported to Congress in the

near future.

I think that if you want information on any one of the specific systems, I'm certain that they're available. You can write to them and they will use that

To go a step further, yes, I think that the issues relative to measurement of quality of care in terms of outcome measures is a little different than the severity index, although some of them purport to use the same instrument with modifications to do outcome measures. The peer review organization is now testing its seven sites. Seven states as testing the medis group system to try to see if it will determine more specifically outcome indicators of care.

VThere are, as I spoke, several research studies going on and the fact that $12 million a year will begin to be funneled out for requests for proposals over the next three years I think is indicative of the seriousness within which everybody is taking that. I think it will change medical care practice. When that data becomes more available, I frankly will foresee the day when you know we turn to the consumer to find out about cars and refrigerators and lots of products. I suspect the day will be with us within a decade that there will be a consumer index for health care providers. You may shudder, but I think it's fast approaching that point in time.

I think what that means really is not to be afraid of those indicators but to apply for some of the research funds and begin to hone in and develop one's own because I would suspect that five yeas from now we'll look back on this and think we're in the embryonic stage and hopefully it will give birth to something meaningful.

DR. SPOTO: Thank you, Dr. Davis.

VOICE: I have a question for Mr. Hunter.

His slide indicated that there was some profit sharing opportunities for physicians in the partners PPO. I wondered if he could describe some of the current arrangement with group practices that offer that.

MR. HUNTER: We tend to try to do those at a local level in a way in which makes most sense for the hospitals and their medical staffs. The model that we prefer, that we prefer to see with respect to those activities at the local level is that there is in place a hospital physician joint venture that the physicians own a piece of with their institution. It seems to us that in these ADS products that makes the most sense, and that, of course, is one level or one play where physicians might share in the profitability of that kind of an activity.

We have them in joint ventures with our hospitals in a number of other areas, like -- things like physicians office buildings in the more traditional physician hospital

joint ventures, and then, finally, because of the instrument that we used to capitalize our enterprises company physicians like hospitals are eligible, depending upon their jurisdiction which really determines how much they can participation in buying equity in VHA enterprises and we encourage that and have offered it to them.

So there is -- basically we see the biggest play at the local level through hospital-physician joint ventures which are the contracting group with the health plan, other physician joint ventures and then, finally, with the rest of the investment community we'd prefer to have our own physicians invest than anybody else.

DR. SPOTO: Let's give our panel a big hand.

(Applause.)

(End tape 2, side 2)

VOICE: Let me start by assuring you that I'm not Jack Rose.

(Laughter.)

Some of you will be relieved; other disappointed. But it's coincidental. We're sorry Jack couldn't be here and I'm standing in partly because I'm from Minnesota, and it is coincidental.

I thought of Jack the other day. Those of you who know him know he's a urologist, and in the Twin Cities in particular, the so-called hot bed of competition, there's

a lot of advertising going on in the health care sector. I picked up the paper last week and on the back page was a mesomorphic male with his shirt off and a linear scar going down the length of his sternum advocating the cardiac surgery program at North Memorial Hospital and, obviously, he'd made it and it was a nice scar.

(Laughter.)

It was a good ad. It certainly got my attention and I would have considered North Memorial if my coronaries were any worse than they are. I was also concerned -- that's what made me think of Jack Rose, because I was worried about how they are going to advertise their urologic program up there.

(Laughter.)

Well, we all recognize that change is underway and we're all here in places like this trying to find out how it really is going to change and are trying to learn the truth. It's hard to know who is telling you the truth, and more importantly, who is not telling you the truth. And I did learn from someone here how to tell when the people from HCVA aren't telling the truth. I'm going to let you in on it. Watch and see if their lips are moving.

(Laughter.)

We're fortunate today, and I say this in all sincerity. We do have someone here today that tells the

truth. I don't know if Steve was an Eagle Scout, but I cna tell you he is honest and he is trustworthy. He's also a little iconoclassic and I think you'll hear some of that today and he's challenging. But most important from our perpsective, I think he's rational and fair. I think he understands the issues, and more importantly, he understands the system that's in place and I think he's goinng to be able to guide the changes that are taking place that maximize the use of the capabilities of the health care system that's been assembled.

I won't read you his curriculum vitae that Jack was supposed to read. We all know who he is and we all know what an influential position he has and I think we can all feel really confident that someone of his ability is in that position.

Dave Durenberger.

(Applause.)

SENATOR DURENBERGER: Thank you very much, gentlemen and women, and, Glen, thank you for being here today.

Speaking of urology, I was at a -- what is this? It looks like a body bag.

(Laughter.)

In case there's a Democrat in there I thought I'd check it out.

(Laughter.)

I was a head table guest a few years ago at a B'nai B'rith dinner in New York. It was a very, very long table and they were honoring a Minnesotan and I sat next to a fellow by the name of Frank Lautenberger who was trying to run for the Senate and deploring the fact that Walter Mondale, who was also there, was working for his opponent and so forth. Never expected to see Frank again and you know where he is now.

But the program started about 8:30 and at about 11:30 they'd finally gotten through Bob Dole and Fritz Mondale and a hundred other head table guests who had to say something. And at 11:30 they introduced the main speaker, who was Danny Kaye. Danny started off by saying before I say a word on behalf of the honoree tonight, I have to say one word of thank you to a person without whose help I could not be here at 11:30 tonight, my urologist.

(Laughter.)

If Bill Gratison were here he would tell you you are now in the City in which sound travels -- the only City in which sound travels faster than light. But it's my City. I'm in charge, just like Rostenkowski and all the other people that will speak to you. I'm in charge. You're on our turf. When we speak, you listen.

A little different when I go to San Francisco and

speak to Palo Alto. I think it is a great honor when somebody will listen on their own territory. But by the same token, when I come out into the room -- into the lobby afterwards people are more inclined to sort of say it like it is than when you come to Washington.

One of the things you have to know about truth, it isn't just Boy Scouts, and I do help little old doctors across the street whenever I can.

(Laughter.)

Part of my function is to help little old and young physicians across the bridge which your program characterizes as -- all I remember is the acronym. It's RWD and RBD. Your rendezvous with destiny or your revolution by design.

I'm complimented by Glen's introduction and I'm complimented by his friendship, as am with the friendship -- growing friendship of a numbe rof people in this room because my job is not to tell it to you like it is or in the sense that -- I mean, I'll tell it to you like it is, not the way I think it ought to be.

I notice in my speeches lately I've coming to characterize myself as a sponge. I don't know whether that's good or bad, but I sort of feel like the person who goes around from one place to the other and sort of squeezes out whatever he knows and then relaxes and listens to the

questions and catches these comments from people and then he goes to the next place and he squeezes it out again. I guess I'm going to keep saying that just to make sure that I continue to act in that fashion.

Dan Rostenkowski told you this morning that they aren't going to do anything until the Senate acts. TVhe reality is they can't do anything because the Republicans are no longer in the House. They all walked out.

(Laughter.)

Only in Washington would you see that sort of thing going on. On the Senate side, on the other hand, the more serious body --

(Laughter.)

-- is working its deliberative way through a $52 billion reduction in the deficit.

I got a call about an hour ago from the President in Bonn and he -- to sell me on sticking with him on his 3-3-3 increase and then he put Don Regan on the line and Don said the President is having a great time. He said, the Germans like him a lot more than the Americans do.

(Laughter.)

I said, yeah, I can understand why.

(Laughter.)

But anyway, sometime this afternoon I have to go and decide whether I'm going to support the President on a

real increase of 3 percent a year for three years or I'm going to support Chuck Grassley and a number of my colleagues on a 0-3-3, and I don't frankly know what the hell the difference is. I mean, one of them says for one year we're all going to take a freeze and then we're going to go back to business as usual.

So I sort of pity you folks having to come to Washington and listen to all this stuff, and you've been selective about tne kind of people that you get up here because we are -- the ones you will hear at this program are all honest and you will wonder why our lips move differently when we speak to you --

(Laughter.)

-- if we are all so honest.

The reality is that each of us will tell it to you as it is perceived in the reality of who we are, and that's a good thing. It gets you 535 different answers, but it's still a good thing because you used to get only one answer. You got the Party line. VThe Democratic line was such and such; the Republican line was such and such, and that's still, to a degree, true.

When we did the social security amendment. Are we going to give the social security recipients a 2 percent cut over three years or not. No, on the one before that. It was on the big package. It was 50 to 49 and all 47

Democrats, plus two Republicans, voted gainst this package. But underlying that -- and I tried this out last night on Paul Simon and Jay Rockefeller and some of these new Democrats. Underneath that they weren't real anxious to do that. Doggone it, the country has a $225 billion deficit, you know.

While things were going gang busters for a year in the economy, they have now flattened out. And the President can call from anywhere in the world and say support 3-3-3 or do this, that and the other thing, and there is much more concern among Republicans and Democrats today as to whether or not just cutting the budget or freezing the budget is really the way to turn this country around.

So, I told Al Simpson when he called me on the way out the door would I support the Leadership Amendment. I said if it's an issue of Leadership I'll support it. If it's an issue of the majority having to set some kind of a pace in this process I'll support it. So I'm going to go back there and against my best wishes, while I'm freezing Medicare and I'm freezing this, that and the other thing, I'm going to go back there and vote for a 3 percent real increase in defense spending, plus something, because I assume it'll end up, by the time the House gets at it, in being down to zero.

But if you look at my voting record it isn't going to tell you anything. It isn't going to tell you whether I support freezes, reductions whatever. What you ought to look at is a book called Neither Madmen Nor Messiahs. It's a book that I wrote last year on the Congress. No, it was on the whole place, Neither Madmen Nor Messiahs. But it's on national security policy, and it is the efforts of a brand new Senator who didn't know the strategic arms limitation from a treaty, SALT, from a condiment when he got started.

(Laughter.)

His effort to try to come to grips with his responsibility to a large national constituency. I have now ended up being Chairman of the Senate Intelligence Committee, which I'm sure suprises some of you, that we'd even have a committee with that name.

(Laughter.)

It also surprises you that last I was not only on Intelligence, I was also on ethics. I'm sure that will come as a shock.

(Laughter.)

So, I did that -- I made that effort and I think a lot of -- the good news is a lot of people here are making that effort.

On the other hand, if you watched television last

Wednesday night, you saw a masterful speech on the state of the economy. Masterful. I didn't see it when it was being delivered because I was making a speech elsewhere. I looked at it the next day on tape. I got a copy of the speech. I read it and reread it, and I have never read anything that was that good. TVhat good. It was a terrific speech because you couldn't see his lips move.

(Laughter.)

The reality, you couldn't see his lips move.

Now, a lot of you believe that government spending is excessive. $949 billion this year is too much, and $969 (sic) next year is $20 billion more too much, and when the President says things like, you know -- what does he say about the Washington Monumet? All this spending is a Washington Monumet. You think about this place in terms of its excesses. We do spend too much and you read about the $600 toilet seats and the $100 light bulbs and the $700 lighted toilet seats and you wonder. You really wonder.

You've been thinking that way for the last ten years and you've been doing something about it and the President addressed that, too. He said the way to get those guys to straighten that out -- those guys. It's always somebody else. The way to get them to straighten it out is -- I think he said, they're so fat the only way to get the fat out is to quit feeding them. Don't feed the monkey. I

mean, don't feed the elephant or don't feed the donkey or whatever it is. Don't feed them.

And starting with Jimmy Carter's election in 1976 and then Gan and whoever it was in California in 1977, it was Proposition 13, you stopped feeding us. You said cut off the water and you did it. All over the country. Massachusetts, Michigan, Minnesota elected two Republican Senators. The country elected a movie actor who was 70 years old President of the United States, re-elected him four years later. Even though he had doubled the debt and tripled the debt service, got back in. Only 3,170 people in Minnesota disagreed that he ought to be president again. Did all of those things.

We gave you a tax decrease. Cut your taxes by 25 percent over three years and then indexed the tax brackets so we couldn't use inflation to increase your taxes. We've got the water off in thsi place and the presumption is we're still too fat. And that's what we're debating up there on the budget. We're still too fat.

How much too fat? Where is the fat today in the Medicare program? Well, even if you could answer that question, how are you going to get at it? Do you get at it by doing a physician fee freeze for two years running? Is that the way to keep those -- the docs at $14.40 while all their expenses are going up?

My friend Bob Kelley from Grand Rapids used to be on the AMA until they kicked him off. I still resent that, if there are of you professional AMA'ers around here.

(Laughter.)

But on top of all of Bob's other problems, his clinic unionized right in the middle of the freeze.

(Laughter.)

Is that the way to get at it? Of course not. Of course not. That's not the way to get at it. After you promised the hospitals that you're going to give them an MCPI, or whatever it is, plus 1 percent or something like that. Is that anyway to get at it? To freeze them? No, of course not. That's not the way to do it.

But that's today's reality because the impression out there is still the system is too fat, and as we look around to try to find people to blame for it we do just exactly what Ronald Reagan did on television. We blame somebody else. It is not Ronald Reagan's fault that the deficit is now $225 billion a year. It is not his fault that the debt service is $137 billion this year and it was only $50 billion when he took office. TVhat's not his fault. It's the fat pigs in Congress that are responsible.

And by the same token, it is not my fault that the society we are in expends $1 billion a day for doctors and hospitals. That's not my fault. It's your fault. All

of you in this room. You run that system, and if you weren't all driving Cadillacs and living in big fancy houses and all that sort of stuff and charging $1,000 a day to get into a hospital and, you know, $50 an hour to come and sit in your waiting rooms and all that sort of thing, waiting to see you for 20 minutes, we wouldn't have this problem. That's what the public thinks. 88 percent of them, according to the AARP, and I know that because I'm now 50 so I joined AARP.

(Laughter.)

But I don't carry my card. I guess my card entitles me to free everything, and that's a whole other problem. And those of you who have heard me speak before know that not only is that another problem, that is the heart of the problem in this country. Everything has got to be free. Everything is have today and pass the bill on to somebody else.

Well, the heart of the problem is not the doctors and the hospitals because we took a national health insurance system where no doctor nor any hospital could ever turn anybody away and we destroyed it. We destroyed it. We took all the incentives away from it to do good. All the incentives away to do good. All the incentives went the other way.

We did that in everything in our society. You

could buy and the last -- since I've been a big boy, eligible to be married, raising families and so forth. My parents promised me I could have a three-bedroom house in suburbs and a fireplace, or two in Minnesota, rec room, acre of land, no undesirable neighbors, way out in the suburb someplace. I could have all that for only $500. In the last 20 years -- up until recently, all people 21 years old and older have been walking around with their $500 check saying I want a nice house in the suburbs, three bedrooms, fireplace upstairs/downstairs, rec room, and so forth because it's only $500.

And you know what happened? When we passed out all those check as a society, those have checks. You can have, have, have. Well, there were more folks walking around with their checks than there were home builders to build homes and houses for people to move into. So what happened? The price of everything went up. The price of everything went up. Price of carpenters went up. The price of lumber went up. Price of concrete went up. The price of everything was going up, so did the value of all the homes go up.

So you could buy a house for $500 down, $10,000 in total, send the bill to the Treasury Department on your income tax deductions, and that house became a $20,000 home in two or three years. You could turn that in, put $10,000

in your pocket and go get another house for $500 down. You could sell that in three years for $40,000. You all know the story. It was all built on having today and sending the bill on to somebody else. We do the same thing as you know all so well in the health care area.

And on Monday I have to go to talk to the Economics Club in Detroit and I'm still trying to figure out exactly what I'm going to say. But I know what I want to say. I want to say to Lee Iacoca and Joe Califano and all the rest of those guys, stop ruining the American health care system.

Gary down here at the East Range Clinic in Virginia, Minnesota can tell you that his docs can't get business from the United Steel Workers. You know why they can't get business from the United Steel Workers? Because the United Steel Workers has another health plan called Group Health up there. Group Health is in effect owned by the unions, or if it's not owned by the unions, it sure as hell is very close to being owned by the unions, and of course the unions want their members only to use their HMO. Don't go to him because he's tied up with one of the other HMO's.

Bob Kelley on the West End of the Range can't get into that business either. Steel workers dominate that whole market.

Well, they sit up there with their $25 an hour jobs, protected from foreign competition by poleticians like me who are interested in providing jobs, getting their $4,000 or $5,000 a year health insurance plan, not contributing anything to it. No premium contribution. Very little utilization contribution or cost sharing. We all subsidize it on the -- on our taxes, and we wonder why in the world doctors have to charge so much and hospitals have to charge so much. You know the answer. Because if it's free, everybody wants it. If you walk in and this is your health plan, everybody wants it.

I want to tell Iacoca that. I want to say if you think you're so smart why -- you wouldn't be anywhere. You guys wouldn't have those million dollar bonuses if you didn't have these huge hidden subsidies that tax the American public. Chrysler runs -- now it's what, $6,000 a year for their health insurance plan -- the average is about $2,000 for a comprehensive plan across the country -- and you're subsidizing all of that $6,000.

And they brag about the fact that they have gotten doctors to do this, that and the other thing. They have saved their employees $58 million. Anybody can do that. I mean, the greatest business to be in today ought to be the second opinion guy.

(Laughter.)

That ought to be terrific. Some of you ought to just sign up to be second opinion surgeons or whatever it is and just live off of that sort of thing. Hell, you know, yes, that's necessary to a degree. I mean it is necessary to re-evaluate the way the practice is conducted. But that's not the -- that's not the way to solve this problem.

But that's what they're doing at Chrysler. They keep their first dollar coverage -- they keep their subsidized $6,000 health plan that they don't need and then they go around blaming the doctors and the hospitals for their problems and trying to nickle and dime them here, there and everywhere, and I'd like to say that to them.

And I'd like to chide them a little bit for the fact that I paid -- you and I both now have to pay $2,500 a year or a car more than we should for their automobiles because they've kept the Japanese out. It raised the price of every automobile in American by $2,500 by keeping the competition out and you're paying that when you buy a car so they can save 44,000 jobs in Detroit at $23 an hour.

There's different ways to spend money in America -- the way we spend it. There's the direct spending that we're debating up there. The toilet seats and social security and defense, and you all understand that one. Then there is the indirect one, which is the Tax Code. That's where we can each to out and buy ourselves a car and send

the bill to your neighbors. I just did it. I bought a secondhand Old Cutless Ciera. It cost me $9,200 with the sales tax and everything on it. So I went to my banker and I said borrow me $10,000. That's the way we talk in Minnesota.

(Laughter.)

Borrow me $10,000. So he borrowed me $10,000 and he said how long do you want to pay on it and I said forever.

(Laughter.)

Give me as long on it as you can. You know what I want to do? I want to pay just interest because interest is a tax on you. Every April 15th -- I got these books, checkbooks in front of me and they're all drawn on the U.S. Treasury on an April 14th or 15th, as the case may be. I sit down and I write out these checks to all of you drawn on the Treasury. There's a check for my car, there's a check for my boat, there's a check for, you know, whatever it is and I send you the bill. And this year we Americans wrote $327.5 billion worth of those kinds of checks, so we could have today, send the bill off to somebody else. So when we get the tax reform, think about that one.

When somebody comes into your community -- if it's in New Jersey, Maryland, Massachusets or New York -- and says we ought to have rate regulation in this community

and we ought to have freezes on expansion of hospitals, we ought to have no more free-standing surgery centers and any competition think about the $2,500 bill on the automobile because that's what you do in that same -- keep the competition out of the community. We'll just sit there with what we got and let the prices go up as the government dictates the prices need to go up in order to subsidize the poor and the medical education and the inefficiency and everything else that we do in our hospitals. But it's a tax, folks. No matter how you look at it, it's a tax.

So, all of those kinds of things go into this budget mix. This whole debate over who is the real Washington Monumet. I mean, how fat is the system. And I would argue to you that the system is getting leaner quicker than a lot of us think, and I would argue in particular that those of you who have participated in the leaning of the health care system ought not to continue to pay the penalty for all of the folks that haven't.

And that's as honest as I can be with you about where it's at today. We asked you -- particularly the folks in this Association, the Group Practice people. We have now freed you up, in a sense, in a reimbursement sense, in a payment sense, to do the kinds of things that brought you together in groups to begin with. But now that we've got you there with the prospective payment system, it looks like

we're going to zap it to you to save money on a $225 billion deficit, and I know it looks like that and I know that for one year that's going to happen to you. This is the last year that I imagine that it can happen to you.

But, the problem lies largely in convincing the American public of what is going on. It is in the public attitude. If the President continues to blame the Congress rather than each of us in our have today/spend tomorrow then you may have problems next year. If people continue to blame doctors and hospitals rather than their own life styles then we may continue to have problems.

Honesty has to start someplace, and some day some president needs to stand up and say we made a mistake.

(Break in tape.)

-- and you do. Are no different from you. But it really is time that our political leadership in this country -- I'm glad you started out by talking about honesty. Got up and said it like it is. Don't pretend that all the fat's in Washington. Yeah, it is. But it isn't any fatter here than it is when these same people like me are back in our Minnesotas or our Californias or our Wisconsins or wherever it is.

So, with all of that under our belt, I understand I do have some time to answer questions. I did not -- I didn't cover where the budget may be at. I might do that

before I -- what do we have? For those who have urology problems or whatever --

(Laughter.)

-- you can all get up and leave now or you can wait until 2 o'clock, when we quit.

The proposal, the so-called leadership package on Medicare/Medicaid was about a $20 billion reduction over three years in Medicare/Medicaid payments. That included $2.1 billion in Medicaid; all the rest was in Medicare. We are working on reducing that, and I'm not -- I can't give you all the specifics because there's probably somebody in this room that's writing this down for publication. We're working on reducing that a little bit, making it a little bit more realistic and also making it possible to get 51 votes for it.

On Medicaid, we'll probably come up around $1 billion -- yeah, $1 billion over three years' worth of administrative changes, third party liability and a couple of other smaller items.

I told Dave Stockman that I would not buy into the theory on Medicaid that you have to take money away from the states in order to get them to change the way they meet the needs of the indigent in America. As I travel the communities of this country, I see change taking place. The problem is the resources and prevention is a good example.

I mean, there is only so many dollars around there, and the last place to go with the money is the poor. So the poor get sicker and more expensive all the time because we won't help them out.

But Dave's theory is cut off the water to the states and they'll change the way they're doing things, and I said that's a lousy way to represent yourself as a Republican. A typical way. So we won't -- we won't do that.

And on Medicare it's really a matter of compromising on the beneficiary side. We won't be able to get the 35 percent on Part B premium so we hope to go part way and we will not buy into the 50 percent reduction each of three years for the indirect medical, but we may have to buy into some kind of a graduated come down from 11.9 down to 50 percent over three years.

We hope to about break even with the leadership package in dollars on direct medical education, and if anybody cares about that, later on ask me a question about it and I'll try to outline how we are going to go about that one. But the freezes are all there, just as you might have anticipate, and they give us time between now and next year to wake up to the fact that you don't turn this country around by putting everybody in iceboxes.

Now I'd be happy to respond to people's

questions.

Yes.

VOICE: (Inaudible.)

SENATOR DURENBERGER: Regard to what?

VOICE: (Inaudible.)

SENATOR DURENBERGER: I didn't catch the last part of that.

VOICE: (Inaudible.)

SENATOR DURENBERGER: Well, I told you I belong to AARP. I know you want to know about graduate medical education and where we're headed and I told you where we are going on the -- in indirect.

On GME I guess you know I put in this block grant proposal a year and a half ago because I was tired of going to meetings of people representing academic medical centers and having them fall asleep. But I tried to tell them that competition was going to kill them and they didn't think that was going to happen.

So I put in the block grant proposal mainly to say you're going to get hurt if you don't act and I would rather you act than I, and a couple of principles are that I care a lot about the fact that whatever medical education system comes up is market oriented and that the financing for it come from a mixed source. A mixed source: public-private, federal-state, federal-state-local as the case may

be, and private contributions. Some contributions from hospitals. Maybe some contributions in some way or another from patient service or something else.

But it's got to be some combination because it's not going to be loaded on patient service in the future.

In the next week or two the Dole/Durenberger/Bentsen proposal will come out and it will look a lot like the Heizel/Petersdorf proposal and we will try to tie it into reconciliation, that is, before June 15. And what we would do is freeze the direct costs of GME at the fiscal 1985 level for one more year, into 1986. We would limit payment for the direct costs of GME to the lesser of five years of graduate medical education or the minimum number of years necessary to meet the formal training requirements for the initial Specialty Board Eligibility which is generally three years.

We will eliminate funding for the direct costs of foreign medical interns and residents and we would direct the Secretary to do a couple of studies that relate to nursing and skilled health professions and to do something about comparing costs in teaching and non-teaching hospitals.

Somewhere in that kind of a framework is the kind of language on the Finance Committee side, at least, that we will try to hang on to to reconciliation. It's not the end,

but it really is important to introduce some sense of the future into the medical education system.

Yes.

VOICE: When you were in California you mentioned that you and Bob Dole were working on (inaudible).

SENATOR DURENBERGER: The question is about means testing, and the progress on means testing is about the same as the progress on social security -- cuts in social security COLAs. It all falls in the category of fairness right now.

Our proposals had been -- or my proposal which I think Bob Dole and a number of others have bought into, but not everybody because there's some question about whether it's the best way to do it, was to means best access to the Medicare system and to begin with Part A -- excuse me, to begin with Part B because we already have a contribution there in the form of a premium. We would drop the premium to 20 percent of program costs from 25 percent where it is now so that the elderly poor were not cut out of the Part B program.

We would then get back 90 percent of the program costs for Part B off of 1 percent of everyone's adjusted gross income, as indicated on their tax returns. Today that means half of elderly Americans would pay something in addition to 20 percent of program costs to be in Part B.

Kind of a bargain.

Eventually we'd like to combine A and B into one plan in much the way that we're now going to competitive medical plans for buying the elderly and the disabled their Medicare benefits. We'd like to get to one combination plan which is your hospital and your medical. You pay one premium and you have a deductible and a set of cost sharing benefits for that, and that, too, would be income tested. We won't income test the social security system. You'll still get your $900 cash every year -- or every month, but you're going to be asked to take a little bit of that to buy one of the best bargains in health insurance, which is your medicare policy.

We would also expand the benefits so that the deductible could cover preventive, routine preventive. We would add catastrophic to it. And eventually the system ought to operate so that the Medicare program is the health insurance program of choice for all elderly and disabled. We should not povertize the elderly to get them into a Medicaid program or in order to get them into a nursing home. But to set up the Medicare program as the health and sub-acute health care system for the elderly and the disabled.

That should permit -- hopefully, if we do it right, that should permit the private insurance system to

come into matching this with the so-called social insurance side or the long term care side of the health care needs of the elderly. So, in a general sense, that's the direction we'd like to see the system headed, and I think that kind of rationality will be a more efficient utilization of resources. You don't have to buy wrap-around policies any more. You buy one policy, and in effect we will get out of the reimbursement game as soon as we can set up a policy in the private sector that people can buy.

I stretched the question, as you can tell.

Yes.

VOICE: (Inaudible.)

SENATOR DURENBERGER: What is Congress going to do with the area wage index?

Well, we all got surprised. You're about in the Part A? We all got surprised because we assumed that when we heard from all of our rural hospitals screaming about discrimination that they actually were being discriminated against. After 94-95 percent of them got their labor index information in we found out, in most cases, that they're being over paid and now we don't know what to do. We're caught in a little trap.

The way to handle that problem, of course, is to get out of DRG's as quickly as possible and into competitive medical plan alternatives. In the meantime, until we can

get out of them though, we need to desperately work on coming up with a severity index so we can get rid of those rural urban distinctions and the rest of those kinds of thing. In the short term, I don't know that we're going to do anything with the labor index.

Yes.

VOICE: (Inaudible.)

SENATOR DURENBERGER: What would you prefer? What might this group prefer? Did you all hear the question?

If we -- go on, be a spokesman for the group.

(Laughter.)

And I'm glad you stood up because I might have left everybody with the impression that I wasn't in favor of the carve out on Part B, and that is part of the conditions that we've put in here. We're using a billion dollars in savings rather than $2 billion or $1.8 or something like that because we want to do a carve out for the participating physicians on Part B.

Now, you tell me what you think this group might think is the best way to do the reimbursement for the participating physicians.

VOICE: (Inaudible.)

SENATOR DURENBERGER: But you'd prefer a percent, depending on what it was?

VOICE: (Inaudible.)

SENATOR DURENBERGER: If anybody disagrees with that, see me afterwards.

(Laughter.)

Thank you very much for asking that question.

Somebody else have a question?

Let me say one thing about capital, if you don't. When we get to tax reform we obviously will get to the heart of some of the capital issues. We don't have a proposal yet from HHS because they can't really make up their mind about what to propose on the capital pass through issue. But I suspect when we get serious about tax reform, which may not happen this year or next, that you will see a lot of changes taking place in the way we -- in the way we tax revenue in this country and therefore some substantial changes in the tax benefits of capital investment.

I don't know what is going to happen, but things like tax exempt bond financing is, as we have known it in the past for private placement bonds, is likely to go out the window. That means that in the short term hospitals and other facilities need to find themselves identified as a public purpose in the community.

You know the discrimination that exists now on IDB's or IRB's or both, that if you're for profit you can't get in; if you're not for profit you can. That's

ridiculous, but so is the distinction between for profit and not for profit in your business.

I would hope that most people that go into the medical profession go into it to make a little money and for the same token, except for the nuns that brought me up, most people that go into the hospital business ought to go in to make some kind of a bottom line at the end of the year and I think we're at the point where we really do need to examine in this society whether hospitaling, like doctoring, needs to maintain the non-profit/for profit distinction because it so distorts the access to capital issue when you do it.

I certainly appreciate people's thoughts on that subject as well.

That's it? I -- oh, I'm sorry.

VOICE: I wonder if you have specific recommendations for us (Inaudible.)

SENATOR DURENBERGER: Oh, I think -- good question. What's the best way to work with us folks?

I always start out, because I really mean it, do your job well. I mean you are -- you are the heart of this -- I forget what it is. Is it a revolution? Or is the issue whether it's been designed or not, or rendezvous with -- or revolution by design. I guess it's both, but it isn't my design. It's really your design. Especially you people in the group practice area really designed this whole

consumer choice competition thing yourselves. Then you came to us and said, hey, you've got to change the financing system in order to get the benefits of our efficiencies.

So I ask you, first of all, to do your thing well and respond to the incentives for keeping people healthy in particular. Those of you in particular who are part of prepaid plans better start showing us one of these days that you are keeping people healthy, not that you're just hospitalizing cheaper or less or that you're doing other things cheaper or less, but just keeping people healthy. Many of you are doing a lousy job on mental health. You're doing a lousy job on chemical dependency, treatment and diagnosis and a whole lot of other things. You need to shape that sort of service up.

But in the large part, I think one of the things that some of us are looking for is whether or not you really step up to the challenge of health promotion, sickness prevention, all of that sort of thing, and where you can't you point out to us what it is that is standing in your way in the reimbursement systems, in the tax systems or whatever the case may be. So that is the most important thing you can do. Beyond that, at the local level, you need to step up on behalf of the subsidies.

Back in the old days when we had a national health insurance system and every hospital was part of it

and every doctor was part of it and you could never turn anybody away, so 20 percent of your business you did for free, you know, and that sort of thing, those days are gone. In this system everybody ought to come, you know, paid for into your clinic or into a hospital. But the poor won't as long as the federal and state government and the people of this country are unwilling to meet the challenge of financing the indigent.

You will not have quality medical education in this country if we refuse as a society to pay for quality medical education. Well, it strikes me that those two areas of subsidies which will no longer be carried in the -- or cross-subsidies that will no longer be carried by the average health insurance health plan bill, you have to step up and speak for prevention. You have to step up and speak for the indigent in your local community. And when we are running around saying cut taxes and give money back to the public and the hell with the welfare cheats and all that sort of thing, you have to step up and be heard from on behalf of those you can't speak for themselves, those who are economically or socially disadvantaged in a community that you see after they get sicker than they ought to be.

I think those are two areas that I would define.

Obviously, as an Association, you do a great job of reacting to (break in tape) advancing the (break in tape)

-- choice and so I put that at the end of the things you do because, through Don and a lot of other people, you already do that sort of stuff quite well.

Okay, thank you all very much. I appreciate it.

(Applause.)

(End tape.)

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(The Hon. David Durenberger)

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EX. 209

SENATOR DURENBERGER: I'm delighted to be here.

I especially like it when the President is able to read off all of those committees, because I know many of you find it hard to believe that the Senate has a committee on intelligence.

(LAUGHTER)

Or on ethics, for that matter.

(LAUGHTER)

I am the chairman of the intelligence committee this year. And tomorrow morning, when you're getting out of bed or something like that, and turn on whatever the CBS channel is, I'll be looking at you from Washington, talking to you about hijacking and things like that.

I am here this evening, first, because I want to be, and because you were kind enough to invite me to be here after I braved the February meeting of the American Medical Association.

And I am here this evening courtesy of my publisher, Piranha Press --

(LAUGHTER)

That's really the name of the organization.

I have a little expertise that I developed after I was elected in national security policy, and I articulated that in a book entitled Neither Madmen Nor Messiahs, which has been on the market since last September. It's kind of

hard to get -- (Laughs) -- wasn't grabbed up real quickly, but --

(LAUGHTER)

There's another one coming out. It hasn't been titled yet, but it's on health policy. And if I can ever get it done -- my editor called me about three weeks ago and he said, "Senator," he said, "Stop sending material." He said, "You're not writing a newspaper, you're writing a book. You have to stop at some point." And I said, "I can't. Things are happening too quickly." And that literally is what is going on.

Well, I want to say a special "Hello" to the Minnesotans, wherever they may be --

(APPLAUSE)

Oh, put them in the back of the room! Hi. Shame on you.

(LAUGHTER)

I was sitting out there when they were reading the resolutions off, and I figured maybe there would be one about the recall of the Senator from Minnesota, especially when you said something about the government meddling in health care and all that sort of thing --

(LAUGHTER)

Well, it's nice to be here, and it's a wonderful group.

Last night, exactly a week ago, I was in Wisconsin speaking to the world affairs seminar that Rotary International puts on along with the University of Wisconsin. And I came in just as I came in tonight, and I was seated as they were in the middle of the program. And they had 900 high school seniors from all over the world who had just arrived that day.

They were in this old college auditorium, hanging from the rafters. And as I got there, they were all being lectured on the rules: The girls will be in this dorm, not in that dorm, 'cause that's that's the boys' dorm, and all of this sort. They had 20 minutes of rules and regulations, and the kids were just terrible by the time I got up to speak. So --

(LAUGHTER)

-- I appreciate the fact that at least you applauded as I was being introduced.

Thank you for mentioning the $7 million Democrat that ran against me in 1982. That's sort of an oxymoron -- Democrats aren't supposed to have $7 million --

(LAUGHTER)

-- at least, to spend on politics. This fellow did.

But thanks to AMPAC and lots of other organizations, $4 million as a matter of fact, I was able to

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retain my seat in the Senate and be with you here tonight and share with you some thoughts on the future of health care in this country.

It's not appropriate to start without a joke. First -- I mean, this is not a joke, but I was just observing as I came in that the toughest part of being a state auxiliary president must be having to sit at this meeting -- having to look out at all those folks.

(LAUGHTER)

(APPLAUSE)

I can understand why some of you aren't running.

But it is a little hard for a Republican Senator who is in the middle of a government that seems to be meddling again in health care to speak on the status of health care policy in this country. And so I do it, or at least I try to do it, in a larger context.

I often find myself somewhat uncomfortable, particularly among physicians, all of whom know much more about medicine and health care than I do.

With this particular group, you all know much more about health promotion and disease prevention than I do. You may not all be in the curative business, but as I look at what you have accomplished for America during the course of your existence, you have done more than all of the insurance policies and all of the everything else we have in

this country to encourage health promotion and disease prevention, even though all of the odds are against you. And that's one of the things I'm going to talk about tonight.

But as I go to the AMA in particular, I feel sort of like the refrigerator repairman who is called out in the country to repair a refrigerator, and he found no one at home when he arrived. And so he tried all the doors. He didn't want to go back into town -- he wasn't being paid by the hour -- so he kept trying all the doors.

He finally found an open door, and he got into the house, and he found the kitchen, but just as he spotted the refrigerator he also spotted a great, big German Shepherd lying right next to the refrigerator. He sort of froze in place. But the dog did not get up and bark. It just lay there with that slow deep growl and those big glaring eyes.

So he edged his way over to the refrigerator and began to work, when all of a sudden he heard a voice somewhere in the house saying, "What are you doing here?" He looked around, couldn't see anybody, went back to work, keeping an eye on the German Shepherd.

Again, he heard the voice say, "What are you doing here?" So he very gently sat down his tool, backed away from the German Shepherd, and started going through the

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house. And he got to the living room, and he found a parrot in a cage saying, "What are you doing here?" "What are you doing here?"

(LAUGHTER)

So much relieved, he went back to the kitchen and picked up his tools, went back to work, with one eye on the German Shepherd. But the parrot kept saying, "What are you doing here? What are you doing here?"

Finally, he threw down his tools, and he shouted at the top of his voice, he said, "Can't you say something besides 'What are you doing here'?" And the parrot said, "Sick 'im!"

(LAUGHTER)

That sort of happened to me at the AMA legislative conference in February.

(LAUGHTER)

As soon as I got done speaking, Joe Boyle got up and -- (Laughs) -- and spent a half-hour saying "Sick 'im" to all of the doctors.

(LAUGHTER)

In February of 1982, I was running against the $7 million opponent, and the President of the United States came out to Minnesota to say some good things about me. And we were in the holding room, just before we both went on to speak -- is this projecting fine? I really shouldn't touch

any of this.

And for some reason or other, I made the observation to the President -- and '82 was tough times, I mean, unemployment was going up, interest rates were still up, and he was saying "Stay the course," and we were all getting cold feet -- but I made the observation to the President that he will be, Ronald Reagan, the last president of the United States ever to have lived his adult life in the Depression. The last one. All the rest of us are another generation. Everybody who comes after this president will be of another generation.

And I don't think anyone had ever said that to him before. And so we began to explore the significance of that. And he lectured me on Franklin Roosevelt, for whom, as you well know, he has a great deal of admiration, and also the conviction that, had Roosevelt lived past the end of the war, that he would have undone the New Deal. Was it the "New Deal" that Roosevelt -- whatever deal it was. Some deal.

(LAUGHTER)

Since that conversation, I have been concerned about what my parents have done for me. And in fact, I started last year to give commencement speeches on this subject, and I'm still doing it. And I'm not going to give you a commencement speech tonight, but I want to talk about

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my parents a little bit and what they have done for me, and what they are doing for my children.

My parents, like Ronald Reagan -- and I don't want to put a generation between the two of us -- but my parents had me in 1934 -- I know I don't look that old --

(LAUGHTER)

But 1934 was a year in which that's all they could afford to have -- was me, literally.

(LAUGHTER)

It was hard to find a job. You know how tough it -- well, no, most of you don't know how tough it was. And I don't remember. But it was the most difficult of times, the most difficult of times.

And my parents came to power in this country after the Second World War, after they had defended our country. They took control of the political system, the economic system, and they made sure that their children would never have to have the way they had to have, the problems they had.

And for 30 years now, the course of our generation, they have been busy making sure that I would never have to worry about anything.

For my shelter, they created the four-bedroom home in the suburbs, with recreation room and large living room and porch and patio, and in my part of the country

several fire places, an acre of land, no undesirable neighbors, low taxes, all that sort of thing, for only $500 down and forever to pay.

And when that was first created, nobody could believe it, but a few people tried it, and it worked. For $500 down, you could have that kind of a home, and forever to pay, and you interest was deductible against your income tax obligation.

So all of a sudden, everybody in the country stood up with their $500 bills and said, "I want one." And we discovered there were many more people with $500 bills that wanted houses than there were houses.

So what happened? If a home was worth $5,000 on the average in that time, what happened? Everybody wanted a house. They'd pay almost anything with their $500 bill to get it. Within a matter of a few short years, all of the folks that had homes, the prices went up to maybe 10 or 15 thousand dollars, because the demand was so great. The cost of materials and labor, everything went up. There weren't enough carpenters. Carpenters were working for $2.50 an hour. You needed more carpenters, you had to pay them $5.00 an hour, to get more carpenters. And that added to the cost of the house, it went up.

So in my generation, I could buy that first house for $5,000, turn it in in a couple of years for $15,000, put

$10,000 in my pocket -- am I going too fast for you? -- no, you looked like -- very good -- put $10,000 in my pocket, buy another house for $20,000, something like that, with my $500 down. In another couple of years, I could sell that one for $40,000, put $20,000 into a new business, and off I'd go again.

And we all did this in my generation.

And now, we have raised the price to my children of a new home, on the average in America, to $86,000. And 90 percent of our children cannot afford a new home.

We did the same thing with automobiles. We all have three cars out there, and we recycle them, one each year. And we did the very same thing. We'd go out and borrow the money, send the bill to the government with our tax deductions, all that sort of thing, and we could always have a new car. So who cared about the quality of the car? You bought chrome, right? My generation had the chromiest cars you ever saw, as we came of age. See?

So we wonder why we can't buy a good quality American car. It's not the fault of the auto workers, or the automobile companies. It is the fault of wanting to have, without wanting to pay for it.

Now, in health care -- I could give you lots of other examples, but let me talk about health care. We did the very same thing. And we did it in the name of access

and quality, and all those other important things. We did it to bring health care to the poor, we did it to bring health care to people in remote areas, we did it to advance the quality of health care, and we did it largely with the employer-based health insurance program.

Health insurance itself meant that you could get the healthy to pay for the sick, and the young to pay for the old, and you'd group all of these people together in an employment setting, and you'd buy them a health insurance policy which they wouldn't buy for themselves. And in 1954, we all looked to Washington and we said, "That's a wonderful arrangement that ought to be blessed by the government." So the government laid its hands on that arrangement, and blessed it.

Blessed it with a tax deduction for the employers for the cost of the premium of the health insurance. Blessed it by making all of the payments by the employers tax-free income to the employees. And -- boom -- what happened in health insurance is the same thing that happened in housing: Everybody stood up and said, "Hey, I want my health insurance."

Not only do I want health insurance, which means financial protection against the things that I can't afford to pay out of my pocket. I want it for nothing. And we gave it to them for nothing.

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How many of us on our first jobs were handed an insurance policy and said, "Here's your health care from the X-Y-Z company." We took it home, couldn't understand it anyway, because the print was too fine and too complicated. But we were covered. We had the great American "Have Today And Not Have To Pay For It." All we had to do is process the bills, pile up the paper in the doctor's office, or whatever.

Every time you had a little ache or pain or something like that, you went to see the doctor, he told you what to do. If you liked what he told you to do, you took his advice. Otherwise, you didn't.

We created a great sick care system in America, by doing this. But again, everybody had it. And pretty soon, it was free, in most employment settings. Today, it still is free at Chrysler and General Motors and Ford and Honeywell, and a lot of other places. Doesn't cost you a thing. Costs the taxpayers a lot, but it doesn't cost the people that go to work at those companies a thing.

So what are those people going to do? If it doesn't cost anything to get sick, why in the world should they stay healthy? Is there any reason to stay healthy, when you can have -- I mean, the whole orientation for my generation was, it's good to go to the hospital, it's good to get sick.

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You go to the hospital, and your employer pays you to go to the hospital. Nice people take care of you -- much nicer than your wife or your husband at home, you know.

(LAUGHTER)

People send you flowers and cards and things like that. But you stay well and stay at work, and you have to work. See? Nobody gives thanks to anybody for staying healthy in America.

So you wonder why everybody smokes. Because there's no penalty for smoking in the financial sense. You wonder about drunk driving, where are the penalties there? You wonder about youth chemical dependency in America, which is an epidemic -- happens to have visited my family. Why? Where are the incentives in this system?

Safety restraints, all of you are working on this sort of thing. Where's the rewards? You get fixed up the same way for being smashed up in an automobile without restraints, on a motorcycle without a helmet, as if you wore your safety restraints. Yeah, you feel better with a safety restraint, you're not bashed up quite as badly, but is there a reward in your insurance policy, is there a reward at work for buying a policy that has restraints in it?

No. Not for my generation. Because we want to have, without paying for it.

You wonder why there are so many hospitals in

this country. Why we say there's an over-supply of doctors. Why there are too many specialties, too many doctors in some of these specialties. Why too much of this, why too much of that.

Not because doctors are greedy, not because anybody is greedy, but because everybody holds up their hand and says, "I want a free health insurance policy, and I want to get sick." So you need a lot of hospitals; don't you? You really do. Every little town in America that has a high school also has a hospital now courtesy of Hill Burton (Phonetic) and excess demand for health care.

So in Minnesota, the place of competition and consumer choice, our hospital utilization in the twin cities is 48 percent. That's because the hospitals refuse to die. But 48 percent. Why not 100 percent, or 85 percent, which should be the average? Forty-eight percent, because we're over-built.

Why are we over-built? Because everybody stood up and said, you know, "I have a right to get sick, and I have a right to have somebody else pay for it."

Why so many doctors? The same reason. No incentives in the society for restraint.

Now, at some point, it starts to pinch. At some point, it starts to cost too much. When the price of a home gets up somewhere beyond 50 or 60 or 70 thousand dollars on

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the average in America, there is an increasingly large number of people who cannot afford a home.

So if you want to put people in those homes without affecting the way we pay for them, what do you do? You go to the government and you ask the government to subsidize the access of these people to those homes. And that's what we've done for the last 15 years, all the tax subsidies, and everything else.

Same thing is true in the health care system. As we price more and more people out of the market, what do we do? We just have to find new ways to subsidize the hospitals and the doctors and the access to the health care system.

But at some point, everyone says it costs too much for what it produces. And at that point -- again, starting from the bottom -- the suffering begins.

At that point, when it pinches much too hard, hospitals have to start making decisions about who gets the first and the best care, and everybody else has to start making those same kinds of decisions. And politicians make those decisions when they're running out of tax money and they have big deficits. It usually starts at the bottom, and that's where it hurts the most. But they are the cries you can't hear, with the poor. And then you start changing the quality of care in America, and that's what's been

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happening. That's what's been happening.

Another thing that's been happening -- my mother, who's now 74, has already sent me a living will. She has decided that health care costs too much and she ought to get out of the way. If something happens to her, she wants me to get together with some poor doctor and decide to pull the plug on her. And millions of elderly people are making that decision, and millions of Americans are saying that's a good decision for them to make.

And at the other end of the spectrum, where we will do almost anything to enable people to live, we're starting to talk about quality of life criteria, so that maybe we don't have to undertake the expense of a spina bifida birth.

That's what's happening in America, because I have to have -- because I want the right to go to any hospital, any doctor, consume as much as I want, including liquor and smoking and Lord knows what else.

So if there is something going on in America today, it is not due to mettlesome government, it is not due to doctors and hospitals ripping off the public. It is due to my parents' generation -- and with the best of intentions -- wanting for me better than they had.

But what is my generation going to hand over to my children, besides $86,000 homes, $1,000-a-day hospitals?

I go on and on and on and on and on and on. That is the prospect of what I am going to leave to my children.

Now, what can we do about it? You know a lot of the things that we're doing about it in prospectively pricing Medicare and dealing with graduate medical education, and a lot of those kinds of things.

One of the main things we need to do is, start in the beginning with the basics. Start where this auxiliary started years and years and years ago, with health promotion and disease prevention. That's how simple it is.

I had a four-hour hearing the other morning on that subject. The first time the Health Subcommittee of Finance has ever had a hearing on health promotion and disease prevention. Why? Because we shouldn't be called the "health subcommittee." We ought to be called a "sick subcommittee." Because that's the program we're running.

We pay you all of your expenses except the first day to go into a hospital if you're 65 or older or disabled. It's free to get sick on the Part A side of Medicare. But will we pay for high blood pressure tests, or hypertension testing or any of that sort of thing? Oh, no. Don't talk to us about that. We'd rather pay for ESRD after the kidney fails, $50,000 a year, than fork out a few measley dollars to provide blood pressure tests.

In Part A of Medicare, we use the payroll tax to

tax away the income of healthy people in order to pay 100 percent of the costs of people that get sick. In Part B, we use general revenue to do much the same thing for doctor and out-patient treatment. But we do zero for screening and testing and hypertension and health promotion and pre-natal care. And that's the one that your organization understands the best.

Four thousand dollars a day to keep a 750-gram child alive, but almost not a nickel invested in the womb. Boy, you know that. When am I going to wake up to that? When are the politicians that represent you going to wake up to that fact? The best incubator of all is the womb.

We have three times, three-and-a-half times as many neonatal intensive care beds in America as they have in most cities in Europe. Why? Because they care about mothers and children; not a fetish for the technological retrieval of a baby that shouldn't have been born that quickly anyway.

We have many other things wrong with our society in that sense that we're going to have a hard time addressing. Occupational health, ground water -- tomorrow morning, I've got three-and-a-half hours of hearing on ground water in America. You can't even see it, but half of us drink it, and it's being contaminated every day by toxic pollutants, leaking underground storage tanks, a variety of

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things.

Those of you here from Long Island, if there's anybody here from Long Island, you know the problem. Your wells are being shut down every day. Acid rain. Lead in gasoline, we're finally getting that taken care of. A lot of things.

All because I have to have, and don't want to pay for it.

Now, a lot of changes are taking place in the financing and the delivery. And it's being referred to as a revolution, and in a way it is a revolution. But in another way, it's just plain comment sense, what's going on today.

Those of us who advocate consumer choice in health care, advocate consumer responsibility. I must be made responsible for the choices that I make. That's how simple this revolution is. And when I go to a doctor, I want him to be able to be responsible for the choices that he and I together make.

So that, if he says, "Quit smoking," there is also some kind of a financial incentive behind that doctor's advice, and a whole lot of other advice that he would like to give me. But under the old system, I didn't have to take his advice, because it didn't cost me anything not to. In fact, I was rewarded for continuing my bad ways.

Some worry that all the prospect of payment

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schemes we're dreaming up, the medical education changes that we will put into effect this year some time, the changes in the way we pay for high technology, and all of that, is just a way for government to balance the federal budget on the backs of doctors, community hospitals, medical education, and the poor.

I pray every day that this is not the case, that it will not be the case. The Part B freeze, for example, is ridiculous. But there is no way this year it can be changed, because this is about year seven or eight of the second American revolution. And our competence for dealing with this revolution is still at the "freeze everybody in place" stage.

Now, I say at the second American revolution. It started in 1976, the bicentennial of the Declaration of Independence. And it started with a tax revolt. And people elected a governor from Georgia -- with all due respect for those of you from Georgia -- elected a governor from Georgia President of the United States, because he promised us that he would change the role of government. He would balance the budget, cut out the bureaucracy, and he would change the fact that what government does in our society costs too much and produces too little. And he got elected.

A year later in California, Jarvis and Gann came with Proposition 13, and every one of you from California

I'll bet voted for it. Because it said, "The only way to get politicians to change the way they do things is to cut off their water." So in California you said, "Yes" to Proposition 13, and you cut off their access to the property tax. And in Massachusetts the next year, it was Proposition 2-1/2. In Minnesota, it was two Republicans senators in one year -- first time in umpteen years that ever happened.

And in 1980, you elected a conservative movie actor, 70 years old, President of the United States, on the same promise: He would balance the budget, cut taxes, cut spending, get rid of the bureaucrats. You put the Republicans in control of the United States Senate for the first time in 26 years, and we're still there.

In 1981, we started delivering. We gave you a 25 percent reduction in your taxes. We gave you 10-5-3, which is accelerated depreciation, for those of you in business. We gave you IRAs; aren't they wonderful? We brought the top rate down on taxes from 70 percent to 50 percent.

And we were rewarded in 1984 with the biggest presidential election victory in the history of this country. Forty-nine out of 50 states -- only those people in the back of the room didn't vote for Ronald Reagan.

(LAUGHTER)

Aww -- don't blame us. Right?

(LAUGHTER)

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Big, big, big victory. But as soon as it was over, we said, "Hey, how about the tax revolt? How about the balanced budget amendment? How about all of those sort of things?"

And people started saying, "Well, if you really want to balance the budget like we elected Jimmy Carter to do and Ronald Reagan to do, then how come the federal national debt is on its way to $2 billion? How come the annual debt service on that debt, which was $50 billion when Ronald Reagan took office is today $137 billion a year, just to pay interest on the debt?" Why?

Tip O'Neill knew why. If any of you have heard me speak before, I tell my little Texas joke at this point, which says, "Why were there so may heroes at the Alamo?" And the answer is, "Because there was no back door."

(LAUGHTER)

And even the Texans understand that, because everybody in the Alamo was from Tennessee.

(LAUGHTER)

As soon as the 1984 election was over, Tip O'Neill made a decision. He said, "Inside this Alamo are all these Republicans and Democrats in the Congress of the United States, and Ronald Reagan, the President. And the public is outside screaming about the high cost of everything in this country, and they want their taxes

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reduced, and spending reduced, and all that sort of thing. And they keep voting in Republicans, and the debt keeps getting bigger."

And he said to himself, "Why is it that this keeps happening?" And he looked around and he discovered that there was a back door to the Alamo. And he noticed that every even-numbered year, Republicans and Democrats alike would go out that back door, and they'd go home, and they'd tell you that they could balance the budget if it weren't for all the folks in the Alamo. Right?

Every one of your newsletters from your congressman tells you, he's got a proposal for a fair, flat, fast tax; he has a proposal for balancing the budget; he will get us out of Nicaragua; he will do all of that sort of thing. It's the Congress that's the problem.

So Tip O'Neill finally said, "No way. I'm going to go stand in the back door of the Alamo." And all the Democrats went and stood with him in the back door of the Alamo. And they said, "No more, you Republicans. You're in charge, you won the election, now you figure out how to do something about the balanced budget and all the rest of that sort of thing."

That's what we're dealing with today. What do we do about it? What do we do about it?

Well, you know what the President wants us to do

about it. I got into this by talking about the Medicare freeze. He wants us to continue to cut spending. He has asked us to, and we have, raised defense spending from $134 billion in 1980 to $287 billion this year.

He asked us to, and we have, increased the spending for social insurance programs from $199 billion in 1980 to $322 billion this year.

He didn't ask us to do this, but we had to do this: raise the annual debt service, as I told you earlier, from $50 billion a year in 1980 to $137 billion this year.

Now, that leaves in federal spending only $220 billion left to cut. Only 220 billion. And the deficit this year is also $220 billion. So some would say there is a grand plan here to get rid of everything except social insurance, defense, and debt. Get the government out of every other line of business. And you could do it, you could balance the budget, if you took us out of the FBI and the drug enforcement agencies, and the National Institutes of Health -- got us out of all those lines of business. You could theoretically balance the budget. You'd come real close.

But folks, if you think it's that simple, please remember the figures I gave you. When you add up defense, social insurance, and debt, you're left with only $220 billion in other federal spending. So don't come to us and

ask us for money to help with state or local based child abuse programs, or chemical dependency programs. Because we're all out of money. We haven't got any money to spend on toxic waste control, or acid rain, or any of that sort of thing. We are out of money. We only have $220 billion in spending, and we only raise $744 billion in revenue.

Despite that, the Senate passed a $295 billion, over three year, spending reduction program. It really is about 195, not 295, because some of the economic projections on which it was based are a little blue smoke and mirrors.

Some of you will say, "Well, go to the tax system." Well, you know, we can't go to the tax system, because Walter Mondale said, "Go to the tax system" -- (Laughs) -- and --

(LAUGHTER)

He doesn't even come back to Minnesota any more. He's looking for the 3,170 people that voted for him, and can't find them.

(LAUGHTER)

Anyway, we're going to do tax reform now, but it's going to be revenue-neutral. We really aren't going to do tax reform, though; we're going to do income tax reform. And we're going to operate on the "KISS" theory, which is "Keep It Simple, Stupid," as you all know --

(LAUGHTER)

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Thirty-five percent, the top rate, 33 percent for corporations, and a $2,000 exemption. Real simple. But how do you get there? Therein lies the rub, and that's where the problems will come with tax reform. How do you get there?

I have to mention to you one subject which is employee-based fringe benefits, because I mentioned it earlier, the free lunch, the generation that wants to have today.

I rode down on the airplane with a fellow from Minneapolis Honeywell. He gets $250 a month in free insurance, paid for by you. He doesn't really need it, but he gets it. Lee Iacocca, the president of Chrysler, gets $3,300 a year, free, for health insurance. He also gets $2 million to be president of Chrysler. You wonder why we, the taxpayers, have to also subsidize his health insurance, but that's the way it works in America.

We have not proposed to tax all fringe benefits, only to put some kind of a cap on the tax-free nature of those benefits. The fellow I rode down with on the airplane told me about a friend of his he was just fishing with by the name of "Miles Gerard." And Miles Gerard is an installer of stereos in automobiles.

He has six employees, and he keeps losing his employees to Shock Electronics, which is one of our big

stereo places in the Twin Cities; not because he can't pay the same thing that Shock pays, but because Shock, being big, has all those big fringe benefits.

That's where it's going in America today. If you've got a talent that people need, they're buying you with tax subsidized fringe benefits. Because Miles Gerard, with his six employees, not only has to compete at the fringe benefit level, he has to pay social security tax, he has to pay unemployment comp. tax, workers comp. tax.

And so, when you look at tax reform as it is currently being proposed, you can see we've protected the poor, we've encouraged people to have children, clearly. We have, some people say, enriched the rich, but that's an argument we shouldn't even get into, because even if you taxed them at 100 percent, you wouldn't raise enough money to make any difference.

But one thing we are doing, we are hurting the upwardly-mobile middle class, and the two-worker family.

The social security tax, the tax on work, which today is $5,480 maximum, in five years will be $7,984 per worker, per year, $7,984. And that's just social security. The loss of the interest deduction will mean something to the middle class, and so is the loss of state and local tax deductibility, particularly if you live in one of those states that has a lot more problems than Wyoming or Nevada,

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or some of those states.

So real tax reform would probably give the middle class a choice of a national tax. And I think if we gave the middle class in America today a choice of a national tax, they'd probably take a sales tax or a user tax, rather than an income tax.

So one of the long-term failures in tax reform -- and we'll probably get some form of tax reform -- is that we still, still, ladies and gentlemen -- my generation refuses to tax our consumption. We'd rather tax work, we'd rather tax income. We'd rather tax property. We just can't get it through our heads that we ought to tax our appetite.

The second American revolution will begin to end around the bicentennial of the Constitution. That's 1987. So it's almost over, folks. All the freezes ought to be over by then. And I think we're going to have a pretty good direction in a couple of years of where this country is headed.

Because in 1987, the next presidential election begins. It won't be anything like the last one. The last one was the last of the old elections. The next one, I can't even predict who the candidates -- I couldn't even tell you who the final three candidates will be for my party. That's how different that 1988 election is going to be.

Gary Hart gave some advice to the Democrats. I notice all the Democrats are giving advice to the Democrats. (Laughs) Unfortunately, only Republicans are listening.

(LAUGHTER)

But Gary Hart said a couple of weeks ago, he said, "Democrats need to get off of trying to save old programs, and get on with new ways to sustain old values."

I'm never going to vote for Gary Hart for President of the United States, but I think in what he just said is where you and the medical profession and hospitals and everybody in this country ought to find our future. Not in saving old programs, but in finding new ways to sustain old values.

And the old value of accessing everybody in this country to quality health care is still a great value. The idea that everyone in this country, including undocumented workers and refugees and so forth, ought to be entitled to as good as we in America can produce is still a great value. But it is also a great value that we should not be rewarded by society for taking our own lives. And we should certainly not be rewarded by society for taking the lives of others, in the many ways that we do.

Nor should we be rewarded by this society for over-consumption. Nor should my mother have to pull the plug on herself because I need to smoke or drink. Nor

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should we deny access to life to handicapped children because "we don't think we have enough money to go around."

All of those old values that this organization stands for and has always stood for in health promotion are the future of this country. Government isn't going to provide the new programs for doing it. We can set a framework, we can help take down some of the old ways. But we can't tell you how to do it.

Consumer choice in health care means, you are responsible for your health, and the medical profession and the people that go into hospital and other health professions are responsible, first for helping us stay healthy, and secondly for finding the best possible way at the least possible cost for curing our illnesses.

So that is what I see at the end of this second American revolution. And yes, it's complicated by politicians, it's complicated by government -- madame president -- it is complicated by big deficits, and it's complicated by over-simplistic approaches to tax reform.

But you in this organization have always been on the right track. You will continue to be on the right track. And I pray that you'll stay there.

Thank you very much.

(APPLAUSE)

(END OF RECORDING)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording
Provided to the
U.S. Senate Select Committee on Ethics
by Senator David F. Durenberger

SPEECH TO

AMERICAN PROTESTANT HEALTH ASSOCIATION

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VOICE: It is a great pleasure to be able to introduce Senator David Durenberger who is, as we all know, Mr. Health and Mr. Intelligence in the United States Senate. I have often thought that to be an oxymoronic combination.

(Laughter.)

VOICE: But he seems to have made a success of both. He is the Chairman of the Health Subcommittee and the Senate Finance Committee, and I would be remiss to fail to compliment him on working so successfully with Senators Packwood and Long in achieving a reasonable and responsible policy on tax exempt bond financing.

I never have met Senator Durenberger personally, but I have heard him speak to this group and to the American Hospital Association and other groups often, and it strikes me that over the long haul the best that organizations and people in our situation can expect from policy makers is that they have a grasp of the detail, that they are accessible and ready to listen to what folks like us have to say, and then make their own informed judgments as to what the public policy ought to be.

One of the things that impresses me, and I know impresses you, about Senator Durenberger is that he achieves

all of those ends, that he has an incredible grasp of the details of our profession and what concerns us. He has certainly proven time and again his accessibility and his reasonableness, and it is a great pleasure to introduce Senator David Durenberger.

(Applause.)

SENATOR DURENBERGER: Thanks very much. I don't have a grasp of your industry. I have a great grasp -- does this work? -- a great grasp for the people that are in this industry, and that is one of the secrets of politics is to know all of the right people, people that will not take advantage of you or of the people that they are supposed to care for, and I do not want to be complimented by saying I know everything there is to know about your industry because I deliberately don't try to know everything there is to know about your industry.

But I do associate myself with -- every year, I guess, for the last few years with the people in this room. I can tell you exactly where we met. Last year we were shoe-horned into a dumb room over in the Capitol, as I recall, something like this, and just barely able to eat because they wanted to expose us to all kinds of Senators. They would come in one at a time, and we would make smart remarks about each other.

The previous year we were in Russell 485, and I

told you one of my -- what is his name, the famous preacher, jokes, Oral Roberts.

But anyway I know you.

(Laughter.)

SENATOR DURENBERGER: If I have a specialty, it is knowing the folks in the business. It isn't knowing the business. So I hope you remember that, too, because some people in politics make the mistake of trying to know everything there is about all of these -- about the details of these things when that isn't really what they were elected to do.

We were elected, obviously, to have an impact on the policies, but to not tell you how to do your business. Now, if there is a difference between the way things are going to happen in the future and public policy in the past, it is precisely that; that you are not going to be told how to do your business.

The whole reform movement in health care is designed to do that by changing the way we finance health care so that we can finance consumers rather than hospitals or doctors. We intend to give you the authority to run more efficient health providing organizations in the kind of sensitive way you would want to do it.

So that is the thesis on which we all operate, and that is what brings us together every year so we can

understand each other, where we ought to be going and where we ought to be heading.

If I have a message this year, though, that is -- each year I seem to have something that sort of rises to the top of the agenda of health care reform. This year the clear winner -- I think last year the winner in that regard was state rates setting. We were deeply concerned about state rate setting. We would watch what Massachusetts was doing and it since backed off of them. We watched when New York was trying to get us all to emulate them, and now we see that they have given up their waiver and so forth, but the great fear was that companies in this country and others, in cooperation with some hospitals, were going to bring us state rate setting, and back to the old public utility system where, in effect, we told the hospitals -- we enfranchised all the hospitals. We just said, "We will tell you how much you can raise your rates every year."

There was a deep concern we would do that in order to hang onto the subsidies in the system. Every hospital had a certain amount of uncompensated care. The only way to take care of that, you know, without radical change which we can talk about here, is to keep all the hospitals just the way they are and just allow them to raise their rates by so much each year. That was last year's concern.

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This year's concern is with the deficit, and the impact of the deficit on your ability to run your hospitals for the people of your community the way you want to do it. It is a very serious problem.

It is a serious problem that the nation has permitted the difference between its appetite and its spending to reach $2.1 trillion. It is serious business that the annual debt service on the debt has gone from $49 billion a year to $137 billion a year. I mean, it is a culmination of a whole generation of having today and sending the bill on to tomorrow, and now those of us who are in the business of delivering or financing the delivery of health care are being told that we have to give up some of our spending on health care in order to rectify the annual difference between what we want to spend as a nation and what we are willing to tax people in this nation. That is the crisis.

When we debated where Medicare would be at Gramm-Rudman-Hollings last December, the fight that Lawton Chiles and I lost was on the issue of whether Medicare is a program of payments for the elderly and the disabled, American health care, or Medicare was a program to pay doctors and hospitals whatever they charge to take care of people.

And the argument that Medicare is just a series of payments to doctors and hospitals won out by 52 to 43, as

I recall. That is the most serious issue that faces us who are in this business together.

Too many politicians that represent each of your institutions believe that there is fat in the hospital system. There is fat in the medical system. There is fat in the nursing home system; all that sort of thing, and the more reform we do and the more efficiencies we build into the system, the more we seem to prove to them that they are right because they don't understand health care.

They don't understand what is going on in your institutions. They don't understand about the subsidies inside the system. They don't understand about how much of your time and effort and money is devoted to education, how much of it is devoted to counseling, how much of it is devoted to uncompensated care that you know when they walk in it is always going to be uncompensated.

They don't understand all of those sorts of things, but they see us bringing that line down, the current trustee estimate on the bankruptcy of Medicare is 1996. The reality is, it isn't going to go into bankruptcy. That is because of you people. You saved us from bankruptcy. The folks up there don't fully understand that. They don't appreciate how you have done that so when it comes to saving some money on the Federal spending side, the big target today is medical.

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The President is proposing $23 billion in savings, I think it is, or is it $18.4 billion in savings over three years in Medicare and about $23 billion over five years in Medicaid. Maybe I have got those figures turned around; but huge amounts of money he wants to, quote, "save," end quote over current spending in lines of spending increase, at the expense of hospitals and doctors. Very unfair.

But I can't win the battle by myself, and you are going to have to find some way to win this battle for us, and I think that is your chief responsibility in a political sense over the next few months, is to impress on your Senators and your Congressmen what it is you are doing.

Now, one of the things that I notice has happened to me in this regard is that I am starting to cave in a little bit in my objections to all of these complaints about how the hospitals of America are dumping people too early, or are refusing to admit them, and all that sort of thing.

I know there are 3,700 documented cases out of 12 million cases of where hospitals have, you know, dumped or something like that; so I used to say, you know, you could have found 3,700 out of 12 million in 1976 or 1956 or something like that.

Now I am beginning to think, well, you know, maybe if we let people think that quality of care is really

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being seriously affected, then they won't keep trying to save money off the Medicare system by knocking off your DRG reimbursements.

That is the kind of quandary I am in, you know. I should be speaking up for the hospitals of America and saying, you know, "This doesn't happen. Where it happens, you know, we know it. It probably used to happen. It is not good providers." I mean, you can't take 7,000 hospitals and say every one of them is perfect. But John Heinz is on a campaign and AARP is on one.

They are all going to get on this thing because folks are being discouraged from going to the hospital, and doctors are being discouraged from using you people as a place so they don't have to get up in the middle of the night, or don't have to have the pressure of, you know, a diagnosis.

You know, everybody is going to use the hospital in some way because it used to be so convenient to use the hospital. Now they use the hospital as an excuse, you know, for not wanting to do their job a little bit better.

So the tensions, I know, are on hospitals in this country today. I really don't -- I don't want to participate in putting the burden of so-called quality of care on hospitals, but I just find myself in this battle over the budget, saying to Chip and Tom here, "Well, you

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know, let's stop using the word anecdotal. Let's sort of take it easy."

So I have a concern about that, and obviously your advice on those kinds of issues would be helpful, but I just -- I have got to tell you that we need you very much on this reform process.

One of the big issues, of course, you all care about, to varying degrees, obviously, depending on which side of 6.9 or 7 percent a year you are on, or percent of the prospective payment for hospital care, is capital, and I think you know the issues as well as I do on capital.

You know where the administration stands. You know approximately where I stand. I have a bill in. We are revising the bill. In some small ways the issues are pretty well laid out. Which base year are we going to use for determining if they want to use old data from 1983? I want to use the most current possible data, get the most recent fiscal year capital data, then require HCVA to rebase their national averaging system periodically like every three years or every four years or something like that.

The length of the transition period, the hospitals want ten years. The Administration wants four. I have suggested seven. It seems like an appropriate compromise. It is closer to the hospitals than the Administration.

The provisions on outlier hospitals, as Tom calls them here, the folks with the big dollars and the new capital and all that sort of thing, we are working on what we call a catastrophic loss provision, and I don't know what goes into it because this is the first time I am seeing it, but Chip and Ed and Tom and all these guys are working on something, and it just sort of works on my theory which is that if 7 percent of the cost of treating a patient is in capital and 93 percent is in everything else, we ought to spend our time on the 93 percent and not be messing around with the 7 percent.

So to the degree that they can effectuate that through the so-called catastrophic loss protection plan, that is my hope. We have got, for example, some big teaching hospitals in this country, including Minnesota, you will all be happy to know. You probably knew that anyway. We stand to lose a lot, and there is no point in doing that. There isn't any point in penalizing people, even though, you know, you can say, "They should have known; they should have known," that sort of thing. I don't think there is any point in it.

There is a line here that says, "Distinguish between old and new capital debt." I don't know what that means, but I do --

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SENATOR DURENBERGER: I have mentioned to my staff -- they don't believe in it, but I have mentioned to my staff that we ought to be looking at treating movable equipment differently from debt for physical plant and fixed equipment. They don't yet have an answer to that one, but I just instinctively think that is something that should be looked at and maybe should be treated differently.

It was not treated differently in my first bill. Hopefully, it will be this time. I think you also know by now that we -- Packwood and I have worked out our so-called differences, tax exempt bond financing and, really, I am pleased to be able to report to you that with the exception of some arguments that will come up, I would imagine, around the issues of advanced refunding, that at least on the eligibility, keeping people out of the cap, making sure that hospitals don't have to compete unfairly with other state issues that might appear to be more politically popular or something, we did get all the 501(c)(3) facilities outside the cap.

So that, I think, is a logical place -- none of us like caps, anyway. I hate caps. I just think we are going to change the system; in some way change the public policy as a part of it, define what is a public purpose. Work at that side of it. Don't work at "Each state can only spend so much," but we are stuck because the House has this

big cap, and everybody wants a predictable amount of money so we are stuck to a degree with caps for some of these sort of things. Well, the issue is what can we squeeze out of the cap.

Well, those are the two big capital issues that will be decided this year. Behind the scene, of course, are the politics of who is going to make policy. Is Congress going to make policy, or is OMB going to make the policy? And I don't know when we are going to resolve that issue or how we are going to resolve it. That is the honest answer.

I think you assume, because you don't see Jim Miller or Doc Bowen or anybody on the ballet when you vote, that the folks you do see on the ballot should have something to say about this issue. The reality is, the way it is set up, they can do all of this capital stuff now by regulation. They do a lot of other things by regulation, and they do intend on July 2, I guess, to publish regulations that you aren't going to like.

So how we stop that is a little unclear. The House tries to stop it on the supplemental, but the supplemental, I don't think, is going anywhere.

So I don't know for sure how we are going to resolve those issues. Doc Bowen is playing, "I am a nice guy, and I am on your side. Trust me." And because we do trust him, we are not going to.

(Laughter.)

SENATOR DURENBERGER: So I am not sure where all of this is going to end up. But we need to find the way to get the Administration to take us in on the act on some of these issues. It is appropriate for them to sit out there waving the deficit thing as a way to keep pressure on us. Otherwise, you would eat us up. You would eat us alive if they didn't keep the pressure up.

So the ideal thing for our situation is to have you pushing from one side and the Administration from the other side, and we make the decisions in the middle.

Some of the other areas that we are working on this year, of course, one of the deep concerns to you, I know, is medical care for the indigent. The best news on that was in the State of the Union message when the President announced that he was doing a study on welfare reform. It is the first time Ronald Reagan has said that since he was Governor of California, the first time that he has acknowledged that there might be a national responsibility for the poor, and that is very, very significant.

Welfare, at least the notion of this President doing welfare reform, implies that he believes that national government does have some responsibility for financing the access of the poor to health care, and that responsibility

is no longer just with the hospital and the doctors of this country.

So we await welfare reform next year as a policy debate that you should participate in, particularly as the Protestant Hospital Association, as people who came into being for care reasons rather than financial reasons. You very much need to participate in this whole, this national public discussion about how a nation provides for those who are economically disadvantaged.

It will be a very interesting debate, a very interesting discussion. Unfortunately, it will be against this huge deficit, make it more difficult to do. As you sit there, and you are based every day with your state legislatures on the one hand, the Federal Government over here, and you have got the county and the social service providers and all. You are in the middle of all of that tension, and welfare reform as a national policy debate gives you an opportunity to play a very important role in where we head on that issue.

So bit by bit we do little pieces of this. We did something on reconciliation to provide some flexibility in Medicaid. This week with various Democrats I am announcing various proposals that particularly help to solve that some of the other low AFDC states, but it is legislation that would prevent states that provide Medicaid

for persons below the Federal poverty level who were not eligible for AFDC. That comes out of the Southern Governors' Conference.

So various of those kinds of issues we are going to try to whittle away. We are going to continue to try to whittle away at prevention. I am on the catastrophic task force, the Blue Ribbon Task Force on Catastrophic. Hopefully, we will come up with a proposal to put catastrophic into Medicare. We may come up with other restructuring proposals at the same time that we are at it. That will certainly be my advice, to do as much Medicare restructuring out of that as we can. If we are doing Medicare reform, don't just do catastrophic. Do a variety of restructuring of Medicare, and to me that means combining A and B and building in wellness benefits and turning to premium financing, and eventually, if we have the nerve, means testing the whole program.

We might as well, once we start into it, not just quit in catastrophic. We have to get rid of the $572 deductible because it is meaningless. All it does is take money away from people unnecessarily. So the combination of doing something about the $572 and the need for catastrophic hopefully will lead us into a general restructuring, point us in the direction of what the role of various providers should be in delivering of care, point us in the direction

of those relationships with long term care and chronic illness, make us look at the fact that so much of the dollars that go into long term care are social service dollars. They aren't health dollars.

If we just start pulling some of these things apart for Alzheimer's and Lou Gehrig's and things like that, you know, we can do things better in a lot of those areas. Maybe through this task force is a place where we can bring up and get the Administration to make some recommendations by next year on those kinds of issues.

So I will quit with a short promotion. You are always generous enough to compensate me in one way or another for my appearances at these kinds of events, and this time my appearance here is made possible by my publisher. Most, I think all of you, have read this famous book, Neither Madmen Nor Messiahs. It is a policy of national security for America. It is a hell of a good book.

Barry Goldwater read it, and now he is reforming the Defense Department. It is that good. It also has pictures of me in it, but it is very, very good. It is back here if you can find it. If you buy the book, I promise you there is a secret in here on how we kill Quaddafi.

(Laughter.)

SENATOR DURENBERGER: You will be the first to

know besides BBC and, I think, ABC was the latest to say that maybe -- but anyway I have been trying for two and a half years to write a good book on health policy, and I haven't got it yet. I hope to have it by the end of the year or by this time next year, but in the interim I pulled together some of a variety of things that I have been saying to you and a lot of other people over the last couple of years about health policy and why we are doing it, where we are headed, and it is now, courtesy of my publisher, it is now in a book called Prescription for Change, and you will recognize that anywhere. It is the Surgeon General or somebody like that.

Anyway, it is called Prescription for Change, Health Care Reform Through Consumer Choice. I am not sure what the price is because you are the first people to even see this book. I mean, it just came to the publisher on Monday so you are the first people to have an opportunity to buy it. If you buy them all out, well, then, there just won't be any for anybody else when you get through.

But I am sure Fred would be glad, if any of you are curious about this book, Fred will be glad to take orders, and I certainly will be proud to personally autograph them for all you great folks.

And now I would be pleased to answer your questions on anything that I have covered.

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VOICE: One comment. I think everybody here owes Dave a substantial round of applause and a vote of thanks for his leadership. He was a little less than candid on the tax exempt bond financing. That is a major victory for non-profit (inaudible) in our sector of the hospital industry, and David has always with major health care issues played a substantial and significant role in achieving a compromise that will essentially, not a Finance Committee -- that is before we go to a conference with Mr. Rostenkowski. Nonetheless, on the Finance Committee having a tax exempt bond financing mechanism that will continue to allow you to have access to capital, and this bill on Medicare capital reform is certainly a positive step in the right direction.

I think everybody has to know how critical David is to your institutions (inaudible), and the other is, this question on the bill before Congress to consider this year a three percent -- if inflation keeps below three percent, social security beneficiaries won't get any increase. (Inaudible.)

SENATOR DURENBERGER: Well, it was offered -- I don't know the answer to that, Fred, because everything is so confused in the budget right now that nobody knows what -- last year, the President recommended it to us, and we were talking about it, anyway, because we were going to freeze COLA adjustments and we were going to do some other things,

so as part of a deal, we offered to help people out with -- if the inflation came out under three percent. I don't know that that deal still holds.

Is there anybody in here old enough to get the benefits of that?

(Laughter.)

VOICE: I didn't hear you mention voucher this time. Are we still --

SENATOR DURENBERGER: We are still on that; we are still moving in that direction, and they are -- you know, the progress is deliberately slow, and we are all learning a lot about health plans and the way health plans negotiate services and just watch us up in the Twin Cities. We still don't know whether we are afoot or horseback, and things change all the time, and one day people are scared to death, and the next day they are happy, and then the next day they are uncertain, and the whole system is really shaking out.

But it is pretty clear that the prediction is that some day there will be half a dozen health plans operating in most cities -- maybe only a dozen or so nationwide, something like that, is probably the way it is going to end up, and people will be buying their -- whether Medicaid or Medicare, will be buying one of those health plans, and they will be buying services from you. That is

the way it is going to be.

Now, how we get there is the learning experience. I mean, we don't know precisely how to do, other than that we need to arm people with the ability to buy health plans, and then we need the ability to measure the value that we are receiving from those health plans. That is the part we are sorting out right now.

HCVA is trying to figure out what it is supposed to do on peer review of these competitive medical plans, and they want to know whether they are supposed to do quality review like the peer review organizations do on doctors and hospitals, or is quality when measuring the purchase of a health plan something a little bit different?

Is it not only how good you treat me in a physical sense, but, you know, how well we communicate with each other, what your hospital looks like, do I feel good there, you know; value in a larger sense -- what other kinds of services are you providing other than repair services.

So we are still moving in that direction. That is not going to change.

VOICE: So many of the decisions on Medicare spending are being made by and driven by the budget deficit. I wonder, with Medicare being funded out of a separate funding mechanism from the general operating funds and having its own taxing mechanism as well, is it really true

that if we cut Medicare spending that we are going to have any impact on the Federal deficit at all?

SENATOR DURENBERGER: No. The only thing you will have an impact on is the dollar figures as currently portrayed in the so-called unified budget. But you have a secondary impact which is to save money. So you are not really solving the deficit problem because the deficit that we measure in Medicare is the trust fund deficit, not the overall Federal budget deficit.

But to try to explain that to people doesn't work very well. So the reality, though, is that you are being asked to make up for defense spending and a failure to raise taxes, and you shouldn't ever miss an opportunity to say this: that the President refuses to let us raise taxes and/or to get more efficiencies out of the defense system because he has a $6,000 per person per year payroll tax which enables him to sustain this spending system. That is what is currently sustaining a lot of spending in this country is the payroll tax which funds social security, Medicare, and everything else. Today that is $6,000 a year, the max, between you and the people that work for you, $42,000, that is $6,000. No deductions, no exemptions, no nothing. Three years, it goes up to $8,000. You have got both a husband and wife working for you, two workers in a family, it will be $16,000 a year with nothing, no

deductions at all.

So what you are doing for future generations by holding down the health care costs and the Medicare costs is simply helping us avoid increases in that payroll tax in the future. But when they say that you are really helping out the deficit by taking a kick, you know, this year or that year, or by getting people out of the hospital early and all that sort of thing, no way, not in reality. You are only helping the trust fund.

VOICE: Do our legislators understand that?

SENATOR DURENBERGER: No. Some of us, those who have been in the social security debate, understand that, but for the people that have to get to $144 billion deficit, they are going to take anything they can find. That way they don't have to touch the Small Business Administration or all these -- they don't have to close up the defense -- the Army base or the Air Force base in their home state, or that sort of thing. They can go pick on the Medicare budget.

Anybody else?

VOICE: Yes. I was struck by your comment that you were now tempted not to engage Senator Heinz in a debate about quality care, and I think that it may have that effect. The concern, though, is that those kinds of statements and presentations that are now being made public are being presented as though this is those bad hospitals'

and bad doctors' way of solving their problem. They have been on the gravy train all this time. The Federal Government has done the right thing by introducing PPS, and those terrible hospitals have now decided to fix their problem by being nasty to old people.

That, of course, is a very, very dangerous argument so I hope that you won't get too close to Senator Heinz and the AARP as they make those kinds of representations because it has the potential for really considerable damage.

SENATOR DURENBERGER: I use that as an illustration of how serious I think the budget matter is, but also as an illustration of some of the political realities that we all are going to need to deal with. And that is, we need to explain what is really going on, all of us.

That is why I keep -- and the question was asked, "Do your colleagues understand this?" And, hell, I can't get to 535 Members of Congress but you can because everyone in here has got a Congressman in your district. If the son of a gun is coming up here not understanding what DRGs are and all the rest of that sort of stuff, it is your fault, not mine. It is your fault, and you --

(End Tape 1, Side 1.)

TRANSCRIPT OF PROCEEDINGS

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Senator Durenberger

Dinner Speech

Part 1, Tape 1

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THE MODERATOR: Good evening. We are going to proceed with our program before coffee and dessert, since the Senator is on a tight schedule, has had a full day, started the morning in Florida, finishing it in Washington, started with the -- what did you call them -- the Health Industry Manufacturers Association, and finishing it with psychiatrists.

It is a real pleasure to welcome Senator Durenberger back to meeting with the JCGR and with the APA. Some of you will recall that Senator Durenberger was with us three years ago in Palm Springs when we had our first State Legislative Institute and at that time made, I think, what turned out to be a number of very accurate predictions about what the future might hold, and so I am especially looking forward to hearing him this evening so that we can plot our course for the next three years until we can get a further update.

For those of you who are not entirely familiar with the Senator -- and I trust that is really very few of you -- Senator Durenberger is the senior United States Senator from the State of Minnesota. He is an attorney who in 1978 made his first bid for elective office and, as a

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Republican, won Hubert Humphrey's former Senate seat. He was then reelected in 1982, and so he has now been in the United States Senate for more than six years and is in his second term.

Of specific interest to us, he is the Chairman of the Senate Finance Subcommittee on Health and therefore obviously the key individual within the United States Senate at this time and for some time already with regard to health care financing.

He does double duty in a number of other important areas, and I think these should be mentioned. He is Chairman of the Senate Select Committee on Intelligence, serves on the Committee on Governmental Affairs and the Committee on Environment and Public Works, all of which have health implications I am certain.

Senator Durenberger's views on competition and consumer choice in the health care marketplace have been at the foundation of some of the initiatives that have occurred over the last several years, and he clearly deserves the title of the Congress' Mr. Health.

On behalf of the APA, I welcome Senator Durenberger.

(Applause.)

SENATOR DURENBERGER: Big podium here, isn't it? It is like the suites in this hotel.

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Thank you very much, Alan. I appreciated that introduction a great deal, and I want to welcome all of you to the day after St. Patrick's Day. Tomorrow the swallows return to San Juan Capistrano. I am Catholic, and my bishop called me and reminded me it is also the Feast of St. Joseph and I am supposed to vote on the MX.

(Laughter.)

And I am sure a good Catholic boy like you is going to know how to vote.

Well, welcome back to Washington, D.C. Bill Gradison, who is a terrific Republican Congressman on health policy issues, calls this the only town in which sound travels faster than light.

(Laughter.)

It is also, as you know, the only place when you land out here at the airport where both you and the cabbies are seeing the town for the first time.

(Laughter.)

Think about that for a while.

VOICE: You won't need to....

SENATOR DURENBERGER: You won't have to. That is right.

One of the things I enjoy about coming to speeches like this is -- there is two things I enjoy. One is to see what picture -- which graduation picture was used

in the program of me, and I think it was college graduation that appeared in this one, and the other is to find out what I am supposed to speak on, and this morning in Boca Raton I had the subject, "The Present and Future of Health Policy from the Provider and the Policymaker's view."

So I am all primed for you tonight, and I have looked at your issues in advance, and we don't agree on more than one or two.

(Laughter.)

So those of you who want dessert now they are going to serve in the next room, and....

(Laughter.)

I spoke right after Alex McMann, who is since 1972 the President of American Hospital Association, a wonderful institution of 6000 dying institutions, and Alex tried to put a very brave face on everything and I followed him with some of the comments that I am going to share with you tonight. Then I was followed by Henry Waxman, who obviously is a lover of the free enterprise system, and --

(Laughter.)

And then I don't know who followed because I had to leave. I don't know who followed us. Frank Young I know was there from the FDA, said Alan is going to get a clean bill of health for the way he handled that heart situation in Tucson. I don't know who is going to get the actual bill

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for it, but --

(Laughter.)

-- he will get some kind of an Oscar or an Emmy or something for facing up to Phyllis George and all kinds of other famous famous.

But Frank did say they handled it very, very well down there. So I am not sure what that means, but it must have been your acting skills.

I was supposed to speak this morning on the subject of health care policy trends, and a point I tried to make and I -- this morning perhaps -- you hear that creaking? Can you hear that? Alan started it. I don't know who is going to end it here, but....

The first observation I have to make is -- and I hear this wherever I go -- somebody -- when Alan mentioned that I was Chairman of the Senate Intelligence Committee, I could hear somebody laugh, and last year everybody used to laugh because last year I was on both Intelligence and Ethics, and --

(Laughter.)

-- can you imagine one Senator being both intelligent and ethical? It is just too hard to believe. But anyway, I know the chuckles came from that side of the room. So I am going to talk to the folks over here.

(Laughter.)

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Three years ago I was in Palm Springs. That is where I met Alan and Joanie, played a lot of tennis, and I don't remember what I said, except I do remember that I was truthful. I said exactly what I believe, and that is what I am going to do here tonight. It may not turn out that some of my comments and predictions come true, but I suspect as I look back over the last three years more things have happened that I suggested might happen than have not happened, and I hope to end this before coffee and dessert comes so that we can have a little interchange and you can ask some questions because I know there are concerns that we both share and which we come to different conclusions, and if I don't cover them in some way in these comments I should do it in the Q and A.

Carol says you have had a tough day. A lot of people brought bad news. Jay and Alan have two more days just like that set up for you.

(Laughter.)

A good thing you are in psychiatry.

But I don't have a lot of really good news for you tonight, despite the fact that we are all coming off fantastic as Republicans, at least a fantastic election, and in part that is what I am going to talk about because this year we are not doing health policy around this place. So there is nothing to go and lobby on. I mean, take out your

long list of, you know, what you think of the CMPs and the mental health coverage and all that sort of thing, and people are just going to go "pttttttttt" like that to you up on the Hill. I mean nobody cares about policy around this place. They aren't worried, as you are, about the access of Americans to a more affordable health care system and one that more adequately covers some of their real needs because this year we are doing budget policy, and that is all.

The unfortunate thing is that last year we did budget policy and the year before that we did budget policy and the year before that we did budget policy. '81 was a big year. '81, we cut spending and taxes, and that sort of set this whole thing in motion. But this year that is it. Budget, deficit, that is the whole issue.

And why? Because simply the 1984 Presidential election has decided all the policy issues in favor of whatever Ronald Reagan believes we ought to do. Except for 3,170 ignorant, benighted Minnesotans, Ronald Reagan swept this election. I mean, we don't count the District of Columbia any more in this sort of thing. So it is just these 3,170 idiots in my state that stood in the way of a complete victory.

Now, they are also standing in the way of my success in the White House, I notice.

(Laughter.)

I am not very popular at all.

But you all know, I don't have to talk to you about how big it was. Massachusetts. My god, would you believe Massachusetts? Huh? Oh, what is this world coming to? Everybody was for Ronald Reagan.

So all of the issues were decided in his favor. The President won the national security policy debate with Fritz Mondale. He won the big domestic policy debate, the deficit, who can solve the deficit. Hands down, he won that one.

So why don't I have good news? Because while he won the national security debate and he won the deficit debate, the problem is nobody decided the "how to's." How are we going to be more secure? How are we going to handle the deficit? Explicitly, specifically.

Tomorrow I cast the first vote on the MX. If I am to vote with the American people on the MX, well, I don't know which American people I should vote for. Now, the American people in November of 1984 said stick with Ronald Reagan. But when I go to the American people and I say do you agree with Ronald Reagan on the MX, two to one they say no. So what is a poor Senator to do?

I got a little problem called Nicaragua.

(Laughter.)

Yes. I got a little problem called Nicaragua and support for the Contras, and even before I became Chairman of the Senate Select Committee on Intelligence I said I was opposed to tearing down the Central Intelligence Agency by making them fight a secret war that wasn't secret and screwing it up in Nicaragua, and believe it or not, four to one the American people support me. But Ronald Reagan wants a secret war in Nicaragua. So what is a poor Senator to do?

(Laughter.)

My left wing is on my right tonight.

(Laughter.)

Or from the rear of the room. You are appropriately seated, right. Nice to be seated in the rear of the room.

Six years. It took six years -- seven years for us to double the defense budget. It was $134 billion in the year that Ronald Reagan was elected. In fiscal '86, which starts September 1 -- October 1 of this year, it will be $285.7 billion. That is just outgoes. That is not authorizing. That is actual spending of money. More than doubled in seven years.

In there are a lot of $600 toilet seats.

(Laughter.)

Also, a lot of $100 light bulbs and some $700 illuminated toilet seats.

(Laughter.)

Did you get that?

You better bring the coffee.

(Laughter.)

There is a lot of waste in that defense budget, and we all know the American public does not like waste. But Ronald Reagan says despite the waste I want $285.7 billion. In fact, in the next three years I want to increase defense spending by $200 billion. So what is a poor Senator to do?

There we go. This is a supportive group. I didn't see any of these issues in your issue paper, Alan.

(Laughter.)

Hell, these people are on my side.

Excuse me.

All right. Now, let's talk about the other one that was decided clearly in Ronald Reagan's favor, and that is what is the -- how do you solve the last -- how do you remove the last big roadblock -- and this is getting close to the health issues -- how do you remove the last big roadblock to permanent economic recovery in America? You do it by balancing the budget, getting rid of the deficit.

At this point I usually tell my Texas joke. It is my only Texas joke, at least the only one I remember, because it is short, and it is a riddle, and the riddle is

why were there so many heroes at the Alamo, and the answer is because there wasn't a back door.

(Laughter.)

Somebody from Texas? No, no. Bad, bad joke. All right.

(Laughter.)

Okay. Well, anyway, thinking about the Alamo and the election and all that sort of thing, I got to thinking, you know, we -- I have been always able to find a back door to the Alamo. You know, all of us politicians up here. You will still find that when you go up on the Hill and talk to people. They are on your side until it comes to the actual vote on the deficit. Then they blame the Congress for not being able to go along, and we have all been able to do that ever since I got here in 1978. We always find a back door to the Alamo. You know, we dump on the Congress and we dump on somebody else, and then we sneak out the back door.

The problems get larger and tougher to handle, and we always say, well, it is not my fault; it is that damn Congress. You know, they are just -- every one of you get newsletters from your members of Congress, and they all say the same thing. Every -- I will swear every one of your members of Congress runs against the Congress itself, and it is our little back door to the Alamo because we don't want to go out there and face those problems.

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So we have a little problem that faces us now. It is sort of an institutional problem. That is we have destroyed the institution, and so we can't use the institution to get out the front door.

Now, fortunately, fortunately, we got two things going for us, the Democrats and the President.

(Laughter.)

You wonder why we got the Democrats going for us. We got the Democrats all standing by the back door, saying you ain't getting out now. You know, we lost that election, you won. See. And there is no question about the fact that you won. So there is Tip O'Neill. I mean, he alone could stand in front of the -- block the back door to the Alamo.

(Laughter.)

But there he is. There is no way you are getting out, you Republicans are getting out the back door of the Alamo.

The second thing is we got a leader who just won this big election. So we turn to the leader and say show us the front door to the Alamo, and in early January the leader said here is the front door of the Alamo. It is a $144 billion deficit in three years, and we can get it down to 100 billion in five years, and we said, what? He said, yeah, and then we will pass a Constitutional amendment to balance the budget, and we said, well, Mr. Leader, that is

not going to do it. I mean, the only way you balance the budget is by keeping your spending and your revenues in at least an approximate balance. You don't do it with a Constitutional amendment. And he said, well, I promised the people that they would have a strong national security and we wouldn't touch their Social Security and we would never raise their taxes, and at that point we said that isn't going to get us out the front door of the Alamo because when we get out there if we have only cut Amtrak and farm price supports and a few things like that, we are going to get killed.

Now, we can cut Amtrak and farm price supports and Medicare freezes, and we can do all of that if we can say we have led you out of the -- to the literal promised land of a balanced budget. Show us something that you can see. Finally, we got some discipline in those guys who always used to run out the back door of the Alamo.

The President said no. He said I like it just the way it looks now. He says look at what we have been doing on spending. He says when I came to office fiscal '80, defense spending was 134 billion, today it is -- next year it is going to be 295.7 billion, I like that.

Social insurance system -- that is Social Security, Medicare, civil service, veterans, military pensions -- was 199 billion. This year, '85, it is 322

billion. I like that.

Interest on the national debt. In 1980, Jimmy Carter's last year -- he was probably thrown out of office because of this -- the interest on the national debt was $53 billion. In one year we had to fork out $53 billion just to pay interest on the national debt. Well, today, 1985, the year we are in now, the interest on -- this year's interest on the debt will be $130 billion. By the end of this decade it will be $200 billion a year just to pay interest on debt. The President says that is the kind of spending I like.

Now, all other spending, all other federal spending after you have now -- we now have 285 in defense, 322 in social insurance, 130 in interest. So we are up at 740, something like that. All other federal spending runs like this. Fiscal '80 was 190 billion. Remember, this is not just the waste, fraud, and abuse. This is the FBI and the Immigration and Naturalization Service, which protects Alan's borders down there and all that sort of thing. $190 billion in 1980. 198 in '81. 197 in '82. 211 in '83. 203 in '84. 230 this year. I don't know how it got up there. Level funded. In real terms, gone down. Gone down.

The deficit in 1980 was 74 billion. Our appetite was that much richer than our willingness to pay. This year it is $222 billion. It is going to average 222 or 230, or something like that, for the rest of this decade

unless we do something about that.

The public debt; that is, the money we owe a public as opposed to owing intergovernmental transfers -- so this isn't the total national debt, and here again is a good reason why we had to get rid of Jimmy Carter and Walter Mondale because the national debt in 1980 was $715 billion. This year it is only 1.514 trillion, and, folks, on top of that we are now a debtor nation. We are just like Mexico and Poland and Brazil and Argentina. In fact, we have their Presidents come and speak to us on how to do it.

(Laughter.)

What it means very simply is we owe more money to people in other countries than we owe to Americans. So the old saw about we owe it to ourselves is no longer true, gang.

The Japanese last year put a minimum of $50 billion into this country. I mean, we complain about the trade deficit. They put $50 billion into this incredible deficit of ours because they can get 10-5/8ths money in this country and only 7.5 in Japan. So the Japanese are very worried -- the Japanese government is very worried because their money is all coming here, and why wouldn't it at that differential?

So what happens to the yen against the dollar? You know. What happens to the peso against the dollar? You

know. What happens to the mark and the franc and all of that sort of stuff?

I met a guy from New York by the name of -- I think his name was Barry Cline, a young man. Among other things, Barry Cline is in the Health Industry Manufacturers Association because he buys safety pins and sells them to hospitals. Millions and millions of safety pins. I thought we had done away with safety pins, but anyway Barry -- well, anyway, Barry buys them from Czechoslovakia, and he pays a 35 percent duty to get them in and he still can sell them cheaper, Czechoslovakian safety pins, than American safety pins. So you wonder why we have a trade deficit.

Now, how did we get to be a debtor nation? Here is how we got to be a debtor nation. By doing just what the public told us to do. Cut certain spending and cut revenue.

The total revenue intake from the federal government in 1980 was $517 billion. In 1981 it was $599. In '82, 617. '83, 600. '84, 666. We about level funded the federal government for the last four years.

Within that revenue intake, corporate and the individual income tax went from $309 billion a year to $350 billion a year. The corporate income tax, which was $56 billion in 1977, is all the way up to $57 billion in 1984. But the payroll tax, which was $106 billion in 1977, is up to $268 billion in 1984. So there are some changes have

gone on inside the way we raise money. Yes, we are not raising any more money. It is level funded. But it is important to understand where we are raising the money. We are no longer raising it from the combination of capital and labor. We are only raising it from work. Up to $39,600 in income per year, a total tax payment of $5,460 between the employer and the employee.

So that is how we got this large debt. We refuse to raise any money, and we continue to spend it.

The Secretary of the Treasury, when he was Secretary -- I mean, the Chief of Staff to the President when he was Secretary of Treasury, Don Regan, told the Finance Committee last year it is better to raise debt than taxes.

Now, I don't know whether he believes that as an economist or a former President of Merrill Lynch or just as a citizen. If it is just as a citizen, I can understand why he believes that. Why? Because one thing the United States public decided as far back as the year they elected Jimmy Carter President of the United States and had Proposition 13 in California and Ronald Reagan in 1980 was the politicians in Washington are not going to get any more money until they straighten out spending, the way we spend money.

So the 1985 federal economic policy and the 1985 federal health policy is to cut spending and not raise

taxes.

Now, the fellow that followed me this morning was Henry Waxman, and he is an articulate Democrat, and I am sure -- I left very quickly so I wouldn't have to listen to this -- but I am sure when Henry got up there he said there might be another hidden federal policy in all of this, and when you look at the President's three-year budget and you see defense goes up by $203 billion, Social Security by 20 billion, interest by 65 billion, Henry just might have said, look, the policy is to get rid of the category "all other" in the federal budget. All other functions in the federal government. I mean, there are a lot of people around this place that believe that we should stick to the national defense business and that is about it. They don't even like us to get into the currency, which is in the Constitution, but they had rather we didn't horse around with that.

Another thing Henry might have said after I left is that one other value in having a large deficit and this big overhanging debt is that no politician is ever tempted to start a new program. See, the thesis is in America that we have discovered all of the ills in our society, we have tried to solve them with federal dollars, and we are very inefficient in doing that. So there aren't any new problems to solve.

Well, those of you from California reading about

the Kirstensen National Wildlife Refuge, those of you from Florida or any other place know that half of America takes their water from -- drinking water from groundwater, and you know there isn't a day that goes by but what you aren't reading your newspapers about toxic pollution in our groundwater. But I am sorry, we have a large debt and a large deficit and no way to solve that problem.

Two Irishmen are up in Canada right now celebrating St. Patrick's Day. One is the President of the United States. The other one is the Premier of Canada. The first issue on the agenda, of course, is acid rain. That one got solved in favor of the Irishman from the United States and his debt. We will not do anything about acid rain except study it.

I have a little bill in on Medicaid that would change the Medicare -- Medicaid program so that state Medicaid administrators could take a little bit of their Medicaid money and spend it on nutritional education for poor, pregnant mothers, you know, the ones that are having their first baby and they don't know anything about smoking and drinking and, you know, a lot of those problems, the ones that are delivering the low birth weight babies and all that sort of thing, and for $58 million, you know, I could enable the states to devote some of that -- some educational money to the best incubator of all, the womb. But I will

bet you I won't get it. I know I won't get it because we are $1.514 trillion in debt, we have a $225 billion deficit, and there is no room in this government for doing something differently.

Now, I don't know if Henry said that or not, but one thing I said about all of this is that we are not going to solve the deficit problem unless we agree as a nation on the definition of government spending. It isn't just the stuff that Peter Grace discovered and that you all laugh about and I laugh about. It is not just the toilet seats and the light bulbs and the food stamp abuses and all that sort of thing.

The first editorial in the Wall Street Journal around the first of December of last year which attacked government spending had on the reverse side of it a one-quarter page advertisement for Cessna, and Cessna in a quarter page in the Wall Street Journal was selling me a single engine airplane. I have checked since, and they run anywhere from $45,000 up to $220,000, or something like that. But the "come on" was two reasons to buy Cessna single engine aircraft, and the first one -- I don't even remember the second one -- the first one was the IRS will give you all your money back. The IRS will give you all your money.

Well, we all know the IRS doesn't coin money.

You do.

So the question, is $58 million better spent, saving us millions, billions perhaps in expensive neonatal intensive care unit beds, or should we spend it on single engine aircraft and/or four martini lunches and/or more interest deduction?

See, that is another side of spending. While we freeze the up-front spending, while we freeze the Medicare reimbursement, we freeze the physician reimbursement again, you know, while we do all of that, even though we promised you we wouldn't even do that once and we did it once already -- we promised we wouldn't touch this reform movement -- we are going to freeze that again. Tax spending will go up $44 billion. Then the following year it goes up $39 billion, or $83 billion in two years, while we freeze physician payments and all that sort of thing.

There is a third kind of spending, and all of you are reading Lee Iacocca's book on what a wonderful American he is, but I figure anybody can be a wonderful American in the car business in the last three years because they have invented another kind -- well, they didn't invent it. We have all invented this, hospitals in particular, society in general. But they invented the franchise system, sort of the certificate of need if you will, of the automobile industry. I mean they decided that the American automobile

industry would look such and such and such and such, it would make 8 million cars a year, and the only way you could do that was to keep the competition out, right?

Of course. So we said you folks that want to buy Japanese cars, sorry, you can't buy Japanese cars. So we keep the Japanese car out three years. You have paid $15.7 billion, or an average of about $3000 per car today, more than you should have paid for American or Japanese automobiles. The Japanese made out on this, also. They weren't in on the deal, but they made out on it, also. But we bought 44,000 United Auto worker jobs at $23 an hour, and it only cost you $15.7 billion to do it. Isn't that wonderful?

Now, in that $23 an hour, we also have those wonderful $6000 per year health packages at Chrysler. Now, I am getting on tender ground because it costs money to add mental health coverage and all the rest of that sort of thing. But at Chrysler you have all heard them talk about it, $6000 per year for the employees' annuitance put together. The average subsidy; that is, the money that comes out of your tax pocket to pay for that, is about $2700 in either taxes or debt.

Now, the average family plan coverage in this country is about one-third of what Chrysler puts on -- or puts up for their employees. So while they go running

around saying it cost $535 a car for this rich American health care system, the reality is if they went at the national -- if they went even above the national average for comprehensive family coverage it would be only $178 per car. The rest of it is a big, damn ripoff, and it is causing you your jobs because this golden handcuff, first dollar coverage, not the government, not Medicaid, not Medicare, it is the business of America to hand out free health care that is making it tough for you to practice your profession.

If your problem is that we are up to here in costs and we got to tighten up someplace, don't blame me. Blame the guys that made a free lunch out of the health care program in America.

We have a $360 billion a year headache, thanks to that kind of thinking. What do we get for it?

Bill Schrader today set a new record. He beat Barney Clark by a day so far with his artificial heart. Barney -- I don't know what Bill is costing us, probably nothing other than Humana's tax writeoffs, but Barney I know cost us $2000 a day, and that is what we paid so that Barney could smoke two and a half packs a day for 25 years. He got $2000 worth of an artificial -- $2000 a day worth of an artificial heart.

So, folks, the problem with an across-the-board budget freeze is that it really isn't across the board at

all. It only freezes those people who get their government benefits through direct government spending. Hidden in all of that is the $44 billion tax spending increase this year and the $39 billion increase next year. Hidden in that is that little thing I saw yesterday on the -- I was telling the folks down there. I guess you read it, too -- the NCAA announced that the great athletes in this country don't smoke or drink any more than do any other college students. There is only 82 percent of them drink alcoholic beverages. Only 27 percent of them smoke marijuana, and only 12 percent of them do cocaine.

Isn't that wonderful? Huh? Isn't that terrific? Pat ourselves on the back. I mean, a wonderful system we got going in this country.

I am going to quickly finish this with just a couple of comments about health policy, but I have to give you that because that is the real world in this place. That is the real world in this place.

The real key to the deficit is not cutting spending and taxes. It is policy reform, and the key to health policy reform is consumer choice.

Consumer choice of lifestyle. If I want to smoke two and a half packs a day for 25 years, by god, I ought to pay for it in some way and not just pay for my heart, but pay for it every single year. When I go to buy a life or a

health insurance policy, there ought to be something big that I can see that represents what I am taking away from preventive health care, what I am taking away from mental health, what I am taking away from a whole lot of other things. I ought to be able to see it.

Consumer choice of competitive health plans. You don't think they are a great idea because of the way they are doing it now, and I don't blame you. If you would look at even the way they work in the Twin Cities, the way they scrimp on mental health, the way they do not buy the best chemical dependency programs that are available. Even in the Twin Cities where we have got the -- we think we have the best in the country -- they aren't willing to buy the best of the services. They want to build them in-house, and they are not doing a good job. So I don't blame you if you look at them the way they are today for being somewhat concerned about them.

Health plan choice of competitive professional institutional providers, and the key to consumer choice is putting a price or a cost on good or evil and on public services. The average American today spends almost 28 percent of their after-tax income on housing, almost 22 percent on transportation, 18 percent on food, 4.5 percent on entertainment, 2.5 percent on tobacco and alcohol, and 3.9 percent on health, and 1 percent on education.

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1 percent on education, 3.9 percent on health. Well, the reason those figures are so small is that they are all free. I mean the health is free and the education is free in this country. There is no price on health in America except in your business, right? Most health insurance is a tax-free benefit, no cost benefit, and the same thing is true of education in this country. It is all free.

So you wonder why we have so many schools. You wonder why we have so many colleges. I mean, my kids are 17 to 21, and I have seen every college brochure in this country, and there is no way to compare them. They all got the same junk courses, you know, and it is just the girls look different. I mean, I got all four boys. The girls look different in the programs or they got more library, bigger, more volumes in their library or something like that. We suffer from an excess because it doesn't cost anything.

But we are starting to put a price on things. The prospective payment system is a lot better than the cost based reimbursement system, even though you may not like the way it works sometimes in a specific. But it puts a price on a service. A lifestyle premium on an insurance policy rather than a group rating puts a price on your lifestyle. An ambulatory surgery center in the acute care area versus a

hospital, or in New Bedford, Massachusetts on March 16th a man was charged with vehicular homicide after his three-year-old son, who was not wearing a seat belt, died in a car crash.

Would that have happened five years ago? No way.

With price competition, with a price things take on value, and if I were to summarize what it is what I was elected to do in the public service delivery area, it was to try to put a value, not just on what I do, but put a value on public service delivery in this country.

You know in the Medicare area generally we are moving to prospective payment systems, and beyond that we are moving out of the insurance business into helping or facilitating the buy of a competitive medical plan. When you get price competition, when you put a price on things like that, you uncover a lot of cross-subsidies. You find all of the things we were doing by shifting costs around.

The indigent we took care of in uncompensated care, nonprofits, public rate setting. Florida has a gross receipts tax -- all kinds of secret ways to take care of the indigent and pretend they don't really exist.

Graduate medical education. You know what we did there. Medicare said we are going to take care of graduate medical education, and now it does to the tune of about 87 percent, though we are going to change that. I don't know

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just exactly how we are going to do it, but we are going to change it. I put in a proposal to change it, which was a block grant to the states, and all of the medical schools went crazy. They don't trust their state legislatures, and yet every state legislature and every governor says we have got seven medical schools, come to Texas. You know. We have got 17, come to Ohio. Come to Boston, we have the best, they say, right? Come bring your medical technology alley, you know, to our community. And all I suggested was why don't you pay part of the bill at the state level, and they said, oh, we don't trust those people in the state legislature.

So now I am working on something else because they didn't like that.

High technology. High technology. That is a wonderful subject. Where does all the money go? Cataract, bypasses we are up to -- what are we up to now? 200,000 a year, increased 700 percent in the last nine years, you know, 25 percent of them unnecessary -- or is it 15 percent? I forget what the figure is. Some amazing thing.

We are inventing all new things every day. We got a cochlear implant now so that people can hear better. Somebody at Harvard Medical School announced a radiation synovectomy discovery so they temporarily ease pain and swelling of rheumatoid arthritis and help people walk. Lots

of wonderful things being invented in America today.

We have made the hospitals pay for them. Hospitals in America have been our national health insurance system, and everybody who walks in the emergency room gets taken care of some way or another, usually off of somebody else's insurance bill.

Capital. We are going to a level playing field, but nobody knows for sure how we are going to get there. One thing I do know is that the future of financing of hospitals and other institutions will be from patient service dollars, not from things like charity and a lot of other things.

When we get to the flat rate tax, which I won't try to discuss with you tonight, when we get to the flat rate tax and we start really leveling the playing field to get the rates down, you will see why tax-exempt bond financing goes, ACRS goes, investment tax credit goes, a lot of that sort of thing. You will see why people who run institutions will be heavily dependent upon patient services, and you will then find how important it is that we address the problems of the indigent, that we address the explicit financing of medical education, that we deal with these problems explicitly. Put the dollars there if you want to take care of the problem.

The last thing, I will just talk very briefly

about Medicare restructuring. So maybe you all can help me look ahead, way ahead on Medicare restructuring.

We talk about expanding the prospective payment system to include all providers as soon as we get a severity index and a relative value scale for non-surgery medicine. We talk about getting preventive benefits into the Medicare program. Get catastrophic in there and people can save billions of dollars on Medigap insurance. Combine Part A and B. Make Medicare elective and means test the premiums. Expand the coverage to all elderly and disabled and include sub-acute care, not just hospital coverage but sub-acute care.

Now, this one looks like it is costing a lot of money because everybody is getting so old, but it is a question of where you take the money from. Right now we are povertizing a whole lot of people to get them into the Medicaid programs, and we have a lot of poor elderly out there that are not being well taken care of, and my suggestion is that we use the social insurance system that we have for the elderly and the disabled and use the Medicaid system for the other indigent in this country.

Finally, in the area of information and quality, we need to know a lot more about our doctors and our hospitals and about prices and outcomes and a lot of other things, not that we use prices to buy doctors and hospitals,

and so forth. That is a little bit of a dangerous business. But information in the hands of the public I think helps them to be much wiser buyers.

And I am just going to conclude with the observation apropos your concerns about coverage that when I didn't know what was wrong with me and I didn't really give a darn because all I had to do was go someplace and be taken care of, or whatever, there was an advantage to mandating benefits, and of course you just put everything in that insurance plan and you got it covered in one way or another. But that is because I was too dumb to know what I was doing.

Now, with cost sharing and with a variety of the other things that are happening to the American public, a more intelligent consumer is going to be a better buyer of health care services. I would venture to say as you look at it right today you say, oh, god, they are going to buy just price and they are just going to want doctor, you know, the hospital coverage and they aren't going to want these other things.

But I venture to say you are wrong, and if I turn out to be wrong, it is because you haven't sold either your profession or your services the way you ought to, and I guess maybe that is -- I am not shifting the burden over on you to get the job done. I am just telling you that if you haven't taken anything away from the first 45 minutes of

this speech, take away one thing, and that is that there ain't going to be no more mandated benefits because we are all out of money. There is going to be nothing new shoved into any of these policies.

So you haven't got anybody to deal with other than the individual consumer, 232 million people out there who are going to have to recognize the value in their lives and the value in their families of the kind of protection and the kind of medical service that you can provide them, and I think it is a wonderful opportunity for you, frankly. I feel that as a father, as a parent. I feel that way as a health policy person in this country, that it is actually an opportunity.

But if you base that judgment on the past, don't believe me. If you base it on the future, I think the future is very good for you.

So thank you for being patient with all of that, and, Alan, I would be pleased to respond to any specific questions that anybody might have. Take one or two and then we will have dessert and coffee.

THE MODERATOR: Well, I will let you take a few deep breaths first, but I know we have a few people here that can come up with a couple.

VOICE: I was interested in your comment on the first dollar coverage (inaudible), and I agree that that

tends to lead to overuse and abuse of the system.

Would that not be also the case with Medicaid, which -- is there any co-pay provision at all (inaudible).

(End Tape 1, Side 1.)

(Whereupon, the speech was concluded.)

VOLUME X

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TRANSCRIPT OF PROCEEDINGS

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VOICE: I would like to thank you all for coming tonight. Our speaker tonight is Senator Dave Durenberger who is going to speak to us on the Federal Government and the internist.

Senator Durenberger is probably the most important legislator in the United States when it comes to health care legislation which is the reason that we are so pleased that he has honored us by speaking tonight.

Senator Durenberger is a Senator from Minnesota. He initially became a Senator from Minnesota in 1976 and later when Senator Hubert Humphrey died and needed a replacement, he then won a very unusual reelection in 1982, - the first Senator in a very long time to be Republican from Minnesota.

He has risen to great prominence in the United States Senate in recent years, and the reason that he is important to us is that he is a member of the prestigious Senate Finance Committee, and he is chairman of the Subcommittee on Health which includes in its jurisdiction the Medicare and Medicaid programs which we are all so interested in.

In addition, those of us from the Washington area

are particularly interested in another one of his committees which is the Committee on Governmental Affairs which has jurisdiction over Civil Service, and many of us have friends and relatives who are very concerned about the plight of the Civil Service in recent times.

He has also served on the Committee on Environment and Public Works and he is chairman of the Subcommittee on Toxic Substances and Environmental Oversight which has jurisdiction over toxic substances in the environment. Some of us have patients who have concerns in that area.

He is on a large number of other committees, but the reason that we want him to speak tonight is because of his expertise on health care, and all of us are particularly concerned about what the Government is going to do to us in the future.

Senator Durenberger?

(Applause.)

SENATOR DURENBERGER: Well, that is a great way to start. I can just do the old line about, "I am here from the Government, and I am just here to help." If you believe that, you will respect me when I get through, or in the morning, as the old saying goes.

I am going to share a few thoughts with you, and I understand that with regard to some of you we have had a

chance to be together before. Don was nice enough to remember Salt Lake City which was about a three hour stand, as I recall, or was it a two and a half hour stand, but what I remember about Salt Lake City was not internal medicine but the fact that the Director of Central Intelligence ran me down there to chew me out because he had read a story in the Washington Post in which I rated him as a two on a scale of one to ten.

(Laughter.)

SENATOR DURENBERGER: So I also remember a very warm welcome, and I remember when I came back, I got such good coverage from the Salt Lake City television stations that Orin Hatch called and said he was upset. So I will now stay out of Salt Lake.

Well, in addition to the committees that Jim mentioned, I am also Chairman of the Senate Select Committee on Intelligence for two years, and I can't wait for the two years to be over with.

Today it got to be rather a long day because in my capacity as a member of the Environment and Public Works Committee I was the author of an amendment on the Clean Water Bill to more fairly treat states like Virginia and Maryland and the Great Lake States.

I spent a lot of time doing that, but I also had to go hear Gandhi speak at noon, and then I had to have

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lunch with his Deputy Prime Minister, and then from 1:30 until 6:00 was involved in various Intelligence Committee meetings starting with Cap Weinberger and the Deputy Secretary of State; and then about an hour and a half of a session on a security failure that you haven't read about in your papers yet that is so almost incredible that it makes me wonder.

So anyway that is what goes into a Senator's day, and then he insists that I come along and I speak on what I am going to do to you. Well, after a day like that I am not going to do anything to you. I need all the friends I can get at this stage so I don't intend to do anything to you.

I will briefly review for some of you the view from the Senate and the Congress of the world of health care delivery, and then I think that we ought to do a little dialoguing to the extent that you have questions.

When I came here in 1978 -- they got bad information on this thing. Hubert died in January of '78. I was running for the Republican nomination for Governor at the time against Al Kwee who used to be a Congressman from Minnesota. Muriel was appointed, decided in April that she didn't want the job, so I moved out of the Governor's race to run for the Senate, started 46 points behind and ended up about 30-some points ahead in the final election.

But I came from a state which at that point in

time was quite a progressive state and was engaged in finding alternatives in the private sector for the delivery of public service.

One of the areas that we were involved, I was personally involved in in the mid '70s was an effort to preserve a private sector delivery system from being converted into a public delivery system, namely, hospitals, doctors, nursing homes, and everything else because at that point in time the heavy trend towards nationalizing our health care delivery system because of the rapid rise in costs was giving us health planning and certificate of need and a wide variety of other things that led a lot of people to believe that maybe the best way to deliver health care in this country was the same way they do it in Canada or in Great Britain.

In the Twin Cities we didn't buy that and so both in health and in lots of other areas we started, a small group of us in business, started exploring how do you maintain a private delivery system in health care, and how can you in effect, if that works, if you find the how to do it part of it, how can that then be transmitted into all the other areas of public service delivery?

So we found the answer fairly quickly, and it is now getting to be the thesis for the revolution or the evolution in the change in the financing of health care in

this country, and it is called consumer choice.

If I have the opportunity to make a choice of a service that I need, I will have more than one choice because the presumption is that not only do I have a choice but everyone has a choice; and if we all stand around with the financial ability to make a choice for health or education or you name it, there is not going to be one hospital out there; there is not going to be one set of doctors; there is not going to be one school system; there is not going to be one anything.

There is going to be a wide variety of providers competing for my business.

So we premised in the Twin Cities what we were doing on consumer choice in the delivery of health care, and we decided the reason there wasn't consumer choice was the fault of businesses, us, the employers, because we had decided, number one, health care was a needed commodity that employees wouldn't pay for so we would pay for employees' health care ourselves; and then we decided that what kind of a package of buys that they ought to make. So we created this Group Health Insurance. We created the insurance or the tax insurance protection for it, and we started filling it in with benefits.

We mandated when chemical dependency became a problem, we mandated chemical dependency treatment.

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Something else became a problem; we mandated that. We went to the legislature and we just -- we filled our benefits programs for our employees, and we paid it all for them with the help of tax subsidy.

So, but they didn't have a choice. "Come to work for my company, the H. B. Fuller Company, which is a specialty chemical company based in St. Paul, and you are handed your health plan. Never looked at. The reason you didn't look at it is because you knew you couldn't understand it because the last place you had one that looked just like it, and the fine print you couldn't understand even if you read it so you just took it home with you. When you went to the doctor, you know, you had a little argument with the receptionist about, you know, "Where is your Blue Cross card or your Aetna card?" or whatever, and if you couldn't find it, she said, "Oh, that is all right," you know.

So then you went home and you processed the paper and you got into this paper shuffle with you and your doctor over how to split up a $60 bill.

But you never really worried about that before the ache and pain occurred or the selection of a doctor occurred.

So we decided that is the part of the system we had to change so we began to make a commitment to consumer

choice; that as employers we would offer our employees a wide variety of choices of health plans.

When that word got out, a lot of HMOs and a variety of other kinds of plans at that time, because this was a coincidence of the HMO act, a lot of people went into the health plan business, mainly HMOs, seven or eight of them, because once the employer with 10,000 employees said, "Whoever wants to come in and bid for that business is welcome to come in," well, they all grew up. And they all came in, and they bid on the business.

And that is how consumer choice and competition began in the Twin Cities.

Now we have an enrollment in prepaid plans of somewhere between 40 and 50 percent of the population in the Twin Cities. We have seven or eight very large HMOs, and we have all the competition that is starting now to invade the rest of the country. So that is where I come from.

I came to the Senate Finance Committee knowing nothing about Medicare, Medicaid, or any of that sort of thing. Medicare was for old folks. I wasn't old, so I didn't understand anything about it. I didn't understand anything about Medicaid. I knew that was for poor people. I wasn't poor, so I didn't know anything about that, either.

So I sat for a year or two under Herman Talmadge and listened to them debate whether, which type of medical

specialty would be qualified for Medicare; or whether the osteopaths ought to quality or whether the chiropractors ought to get cut in, and if so the straights or the crookeds, and I listened to the ophthalmologists and the -- whatever all the rest of the eye doctors are, all debating about who ought to get.

And I said, "What the hell is going on?" I don't know anything about the insurance business; and I didn't get elected to -- I got elected to replace Hubert Humphrey. I didn't get elected to go into the insurance business. I couldn't understand how Herman and all the rest of these people could just sit around and play games with this big insurance company called Medicare.

So I made a commitment to sort of try to do at the national level with consumer choice what we were doing in the Twin Cities, and that is how I got involved, and you are very kind to say that I am semi-expert on the subject. I really am not. I have a philosophical bent in the direction that I have just articulated. But that is how I got into this business.

I got into it at a time when the public was deciding we really needed to change things in this country. In their perception everything cost too much and produced too little, and it was only in the areas where they were insulated from the actual costs that they weren't doing much

about it. In places where they had to pay something, by gosh, they were jumping up and down. They were voting down school bond issues, and they were doing Proposition 13 in California, and where they could get their handle on some politician, they would. But in health care they weren't yet very involved.

So several of us started the process of consumer choice working and started changing the way in which Medicare, for example, finances the delivery of services.

In 1983 we got the prospective payment system started for hospitals. In 1986, perhaps, we will expand that to include some other providers. By 1987 that may include the doctors, for all I know, one way or another. And along the line we, in the larger sense, are changing the way the consumers of this country buy their health care.

We are also changing the way you deliver health care. We are particularly changing the way -- the definition of a hospital. There aren't very many places called hospitals any more. Everything that used to be a hospital is now a health center or a medical center or something. It is a group of very talented people with an outreach into lots of lines of business that have something to do with the delivery of health care.

We are losing the old definition of a hospital, and that is a good thing. That is a good thing. We are

seeing a lot of talented people come into the area of health care administration. We are seeing the so-called growth of corporate medicine, meaning the group practice, the clinic practice, that sort of thing is where it is going to be a. We are seeing people like my friend Chet Anderson from Hector, Minnesota, who for many years was the President of the American Family Practice Association quit.

Chet was an original Barry Goldwater supporter so I don't know whether he quit in a pique or what, but he said, you know, "I can't stand it when I can't practice medicine, when only the way I can do it is in an HMO or some other kind of a group."

So I read in the paper the other day that he quit, and he is going to go off and sort of study what is going on. That is happening all over the country right now. In Minnesota the doctors, instead of coming and listening to Senators, are having evening hours; or they are making home calls like they did when I was a kid. Either that or they are going out of the doctoring business and they are going into something else.

There is clearly this dramatic change taking place out there, and a lot of concerns about it, but also a lot of acceptance, I would say, of the fact that the fears that we were going to nationalize the health care system or socialize the health care system, I think are pretty well

gone.

The fear now is that the private sector is so competitive or so something that it is an uncomfortable place to be. There is a fear now that the professional practice, instead of being taken over by the Federal Trade Commission or something like that, is going to get taken over by Sears Roebuck or General Motors or, you know, some big insurance or investment banking conglomerate is going to control a bunch of the hospitals and the doctors and all that sort of thing.

So it is a different kind of fear now that I see expressed in a lot of professional circles, and it is just the opposite of what it used to be. It used to be the fear that Government was going to take over. Now the fear is that somehow Government is manipulating this process by which the private sector is going to take over, and General Motors is going to be practicing medicine. For me that is, as a person who is not a doctor and so forth, that is a healthy sign because it means we have at least turned the corner on the issue of where the decisions are going to be made about the delivery of health care. It means we are going back to the point where the doctors can make the decisions, not the Government or not the third party insurer or something like that.

I have this personal belief that has never

wavered; I have never wavered from, that the doctor is the key in the future of health care, and in the long run it is the doctor, maybe in a corporate setting or something else, it is the doctor who is going to make all the decisions about my health care.

But from now on he is going to be rewarded, or she is going to be rewarded, for those decisions; rather than have me leave him or her and go to somebody else because he preaches non-smoking or non-consumption of some toxic chemical or something like that, no, I am going to have to take his advice.

Otherwise, you know, I lose him as a doctor rather than the other way around, because what is clearly happening in America today is that we are starting to wake up to the fact that there are ways to save money in the sick care system, and principally -- we are going to have a hearing on this all morning tomorrow -- it is by preventing sickness. It is by committing personal resources, collective resources, to maintaining our health.

Now, that is not an add-on. Five years ago that was an add-on to your health plan. You had all this sick stuff in the health plan. Then if your employer could afford it, you added a wellness benefit or something else.

Today what is happening is they are going to start cutting back on the sick care part of it, in the sense

that there is going to be cost sharing and so forth for people, but there is going to be a recognition that if you can keep people well, everybody gets to make money. The person makes money in a lower premium. The owner of the health plan makes money, whether it is a doctor, hospital, or whoever -- makes money by keeping people healthy.

We are in the process of starting to change individual incentives in this country from, "Anything goes; somebody else pays the bill," to a set of incentives in which wellness and all the good things are rewarded.

For me that is the good news in the system, as somebody who is a marketplace person and all that sort of thing, that is the way it ought to work. All the incentives ought to be on the side of wellness rather than on the side of sickness, and I could preach to you about Barney Clark and about smoking, drinking, but you all in this room know all of those things. You know how as a society all of the signals have been to get sick.

Every one of us as we grew up learned that the place to get your rewards is by going to a hospital. You go to the hospital; you get a day off from work or three days off from work. People send you flowers. They come and visit you. They say nice things to you. You have beautiful people taking care of you, and all the rewards in the society have been in getting sick.

If you stay well, you have got to go to work. You have got to earn it so that is changing, and that is the nice thing that I see going on.

The thing that hurts that is going on, and that will hurt for some period of time -- and then I am going to end this, and we are going to converse -- is that the health care system, like the telephone system and the airline system and a whole lot of other things, has operated pretty much on the principal that those who can afford to pay ought to take care of those who can't afford to pay.

So we ran the sick care system, or the health care system, much the way we ran the airline or the telephones. We would bill the folks who made long distance calls to take care of the folks that had the expensive farm to farm service.

We would bill the folks that made the trip from Washington, D.C., to LA in order to pay the folks who made the short trips from some town nobody ever heard of to some other town nobody ever heard of.

And in health care we paid for medical education. We paid for high technology, and we paid for the poor and the indigent out of somebody else's contribution to the health care system.

So as consumer choice, competition, particularly price competition, have come to the marketplace, it is the

poor who will suffer. It is medical education that suffers, and it is the advance of technology that will suffer unless we learn how to deal explicitly with those three needs that we have.

We should not curb technology. We should not curb the quality of medical education, and we should not deprive the indigent of access to an equal quality health care.

But the only way to make sure that each of those three is properly taken care of is to deal with each of them explicitly. Rather than hiding them in my bill or my premium, pay for them explicitly. And that is what we are up to right now.

The easy ones you can deal with fairly readily as we are in the graduate medical education legislation that Bob Dole and Lloyd Bentsen and I have proposed. The hard one to deal with is the indigent because that is all mixed up in this business about over-spending, over-taxing, over-governing, too much Federal Government, the best place to meet people's needs is at home rather than somewhere else.

I spoke to the Economic Club in Detroit a month ago, and before my speech at noon I had all the hospital administrators and some of the heads of the medical associations together to talk about the Detroit area.

One of the things I learned is that in Detroit

last year there was $86 million in bad debt in the hospitals, $22 million in free care and $12 million in Hill-Burton obligation. Man, I just -- I don't know what the figures are around here, but that just blew my mind.

Then a fellow by the name of Paul Broughton who is the administrator at Children's Hospital in Detroit said, "Senator --" this is what really got me. "Do you know what the biggest killer of kids was last year?" I said, "No, what was it?" He said, "Poverty." Man. You all know that, but I didn't know it was 10,000 kids died of poverty last year.

But am I going to do anything about it? Hey, I have got a $225 billion a year deficit; I got a $2 trillion national debt. I am freezing Medicaid. I am not increasing it. In fact, for the last 12 years I have been reducing the Federal contribution, financial contribution, to the indigent in this country. But don't look at me. I am not responsible for Detroit or Washington, D.C., or places like that.

You have got to look to state governments. They are all in surplus. Well, you look to the state governments. What are they doing? In a progressive state like Minnesota, we elected a Republican House last year on the slogan to give the taxpayers back the money that they weren't -- that Government wasn't entitled to.

So my legislature this year is in the process of giving back $1 billion. Are they going to spend any more money on AFDC? Hell, no. Are they going to spend any more money matching MCH? Of course not. Are they going to put any more money into Medicaid? Of course not. Even though by Medicaid isn't really being sucked up by the children, but being sucked up by old people who are povertizing themselves to get into nursing homes, eating up all that Medicaid money so it can't go to children. That is where the states are at.

So that leaves you in the city. What are you going to do in the cities? Well, the President says we are going to get rid of general revenue sharing. We are going to get rid of the deductibility of state and local income taxes, you know. We are going to get rid of tax exempt bond financing. What are you left with? You are left with the property tax. We will have to discuss the property tax with you as a source of income.

I will have to give you that speech because I think you all who practice in this city share my concerns for the poor, but there is nobody out there making any noise about it, let me tell you. As somebody who sits up there on the Hill waiting for somebody other than Marian Eddelman or some of the people that you traditionally hear from to start saying something about the indigent in America. The

voice isn't getting through.

So in the short term that is going to hurt, because as we clamp down on DRGs and we do all that sort of thing, we are creating problems for the inner city, teaching hospitals, medical centers. We are carrying a large part of tertiary care for the indigent, and I'll be darned if I know exactly how we ought to deal with that.

I am trying to deal with it this year in the adjustment we make on indirect medical education. There is money to be made on indirect medical education, as some of you who are associated with hospitals probably know. We have discovered that so we are going to cut back on that.

But in cutting back on it, we need to do some adjusting for those inner city hospitals or those hospitals that have the disproportionate share load. We are going to try to work that one for awhile.

But that all is temporizing on a very, very serious problem. I know the solution to financing it. I don't know how to raise the money out of the way I have described this in the near term. I know how to do the financing.

And how to do the financing is to simply buy everybody into a health plan. I go to work for the United States Government. For $35 a month I can have a pretty good health plan from a choice of 22 health plans. Not a bad

deal. The Medicare people in this area ought to have that same choice; and the indigent ought to have that same choice.

You don't put them all in one hospital or something like that. Give them a choice of health plans, and pay for that choice. It would be a lot cheaper and a lot simpler than the way we have been running these systems. But you can't get local politicians to do that. They would rather own the hospital, and they would rather control the system, and all that sort of thing, so it gets to be hard to do.

The answer to the indigent is the same as the answer to Medicare and the same to employed people. That is, help people buy a health plan of their choice, and from then on let the plan buy their services so that when you come in with your plan card to the doctor of the hospital, the doctor doesn't know whether you are coming from the Government or a private employer or you are coming from Medicare or you are an indigent person. They can't tell the difference.

That is the one way we can be sure we don't have two-tier or three-tier health care in this country, is to just accept the notion that everybody is going to have the same -- you might have a slightly different set of benefits, and some of the cost sharing may be different from one plan

to the other, but that is the way to handle the problem of the indigent. Somebody has to raise the tax money to buy them in, and therein may be the rub. But there is no other choice in this price competitive environment in which we live right now.

So that is, ladies and gentlemen, sort of the broad brush approach to where things are headed right now. I would love to talk to you about tax reform. Those of you who can afford tax shelters, they are all going. Or anything else you would like to talk about -- ground water contamination or graduate medical education.

Yes, sir?

VOICE: I appreciate your comparison between the medical community and our telephone system because in my experience in the last few years the quality of service of the telephone system has dramatically increased, and the price of telephone service has dramatically increased, and it is my concern that medical care may fall in the same category if Government participates in the break-up of medical care as it is given today. I was wondering if you had any statistics on the experience in Minnesota on --

(End Tape 1, Side 1.)

SENATOR DURENBERGER: -- is that a lot of the employers priced their contribution to these competitive products at the going price for the plan that they already had in place. If they were paying $200 a month, they said, "We will pay $200 a month." So an HMO could come along that probably could have done it for $150. They came along and charged $199.95, and that is still going on out there.

So if you are looking at it from the standpoint of premiums, you can't see it there.

If you are looking at it from the standpoint of the cost of a hospital day or something like that, you are not going to find it there, either. That is because all the hospitals are still in business.

I think within a year about a third of them are going to be gone. I mean, it is going to happen just like that. But in the Twin Cities it hasn't happened because we have this progressive feeling that everybody has to -- we can't kill anything up there.

So one of the unique things that has happened is that nobody has gone out of business. The average utilization now is down under 48 percent for the hospitals in the Twin Cities. There is nobody that can afford to stay in the business at that kind of rate.

What they are doing, though, is they are going into all kinds of other lines of business and so forth, but

they are now just at the point where they are starting to strangle.

What happened in the last couple of months is a rumor got out that one of the better HMOs and two of the best hospitals were talking about coming together, and it just got out as a rumor. All of a sudden everybody was talking about combining, and so I think within -- by the end of this year you are going to see about three or four major health plans in the Twin Cities. All the hospitals are going to be lined up with them. A bunch of hospitals are going to be out of business, and it is going to happen real, real fast.

Where you see it, in dollars, in that sense, in the dollar measurements, it is very difficult in a large macro sense to quantify the benefits. But if you look at it in terms of wellness, in terms of non-hospitalization -- I think what I am saying to you is, a lot of those HMOs made a lot of money, and they have spent it on marketing and on a whole lot of other things, and that is because of the way the market got structured, not, you know, for any other reason.

Do you want to follow that up?

VOICE: Right. My concern is that you are shifting a cost from one area to another area without really changing the bottom line which is the total cost which is

the thing that we are all interested in controlling.

The thing that I am concerned about is that this total cost shifts from one structure to another structure with a second structure's controlling that cost, is actually poorer than the first system.

SENATOR DURENBERGER: I hear that.

VOICE: In the long run the rate of rise of cost may actually be greater which is what I think I see in the telephone system. The rate of rise has been much greater since AT&T, and it appears to me that this might essentially happen here.

SENATOR DURENBERGER: Yes?

VOICE: I would like to echo what Dr. Summers said and ask two questions.

First of all, is there any concern on the part of the Government at this point in time that the cost effective medicine that they are looking for is not necessarily good quality; and two, why is it that Medicare eligibility is based upon age rather than need?

SENATOR DURENBERGER: First, we have a concern that both of you have expressed about cost taking over the -- and quality coming in second. Obviously, we have to have that kind of a concern.

How can we assure ourselves of quality? In the long run that assurance has to come from the licensure

process. It has to come from -- in the near term it comes from some combination of peer review, the licensure process; you know, a variety of things like that.

In the long run as I listen to doctors talk, I am led to believe that the old cost-based reimbursement system was the greatest impediment to quality health care. Two reasons.

One, you couldn't tell a good doctor from a not so good doctor. Everybody got paid the same thing. The line between them was about like that. Obviously, there is some separation, but the line was about like that, and you could over-utilize to compensate for a lack of skill or for whatever; or you could just -- the difference in the practice and it didn't make a whole heck of a lot of difference.

The difficult part of that was, and I am just obviously quoting other people, particularly specialists. The difficult part of it was that the really good person couldn't go up like that. He was sort of held, or she was held, in that kind of a line.

So that one of the advantages to this kind of a system is that the better doctors or the better hospitals or the better whatever ought to be rewarded with a larger number of patients.

Related to that is the whole business about the

way physicians practiced and the whole practice style issue. Again, I am just quoting other people, not dictating an outcome. The reality seems to be that there are a lot of people sicker in this country because of unnecessary medicine that is being practiced. Whether that is true or not, it depends on whether or not you believe Winburg and a whole lot of other people who have done an analysis of unnecessary this, that, or the other thing.

So one of the things that choice and competition does is give physicians information about how to practice medicine.

At the same time you have the malpractice problem which we could talk about all night. It comes to interfere with that one. When you start to change your style and try to practice more conservatively, some jury comes along, or some lawsuit comes along and whacks you. But that is another part of it.

The other interesting thing that I hear, for those of you associated with hospitals, and I hear this almost everywhere that I go. Doctors talk to me about their inability to discipline some of their peers; that they would like to deny admitting privileges to Dr. So-and-So at the hospital, but Dr. So-and-So -- because they know how he practices, or she, as the case may be. But they can't do it because Dr. So-and-So says, "You try that and I will nail

you right to that wall. My lawyers are -- a million dollars, and --" I have got to tell you, I hear this everyplace in America, from physicians who say we have never had the ability to sort of discipline ourselves in that regard.

So I think that one of the things that is available to us as consumers in this future is that sort of thing. Now, we have to put some things in place, and we have to have some protections for doctors who make decisions like that about not admitting somebody to practice in a hospital. We have to protect that hospital, or we have to protect those doctors who made that decision. Or if it is in a group you deny somebody access to your group for that same reason.

We have to have a societal legal structure that protects people like that. So are we sensitive to that? Yes, we are. Do we have the answers readily at hand? No, we don't, but at least we are sensitive to it.

On the Medicare question I introduced a bill two years ago to means test the Medicare program. It hasn't gotten off the ground, but I am still here to talk about it, and I am willing to go back to Minnesota and talk to the senior citizens about it. A lot of them understand that -- as long as I don't touch the cash part of it. The cash part is their entitlement. They are doing pretty well on the

cash part, but nobody said I had to give them free health care on top of that. I mean, the whole theory, when Medicare came along, was to have something there that they could buy into with their cash. So, okay. If that is the case, then why can't we needs test that thing?

So I have a relatively simple way of doing that. It just works off of people's tax returns. I don't know when we will ever get around to it. I hope we can.

Yes?

VOICE: In the District of Columbia we physicians have a large number of patients who are poor, and you mentioned that they are in trouble, given the current -- what can we as an organization of local doctors who are concerned about the poor do, given that we don't have a United States Senator?

SENATOR DURENBERGER: Jim's question is about what can local doctors do about this problem of the indigent. I am not sure what, at just a local level, you can do. I talk about this mainly at national organizations and encourage them as associations to take up this issue of indigent care, and to do it nationally, because you can't let me cop out and say I am out of money. You know?

You can't let me say I don't have an obligation to the poor. My God, what kind of a country would this be? If the President of the United States gets to say, you know,

"Let them vote with their feet," the reality is this President has said that about three years ago, and he has never taken that tack, and he has never said the national government has an obligation to the poor. Somebody ought to make this President say that, or some other Republicans. I don't mind saying it, but then that makes me a moderate or a liberal Republican. I get in trouble.

But at least we need to acknowledge that responsibility. We can admit that the way we have been doing welfare and everything has wasted a lot of money, but I don't think a lot of people know that we are willing to take on part of that obligation.

So we need to focus on that. The states need to focus on that. One of the things we need to do, and this ties into both of these questions. If we would reform Medicare so that the Medicare program took care of not only the acute care needs but also some of the chronic care needs of the elderly and the disabled, so people didn't have to -- I talked to Jake Javits about this yesterday, you know. You all know the condition Jake is in, and he wants to go on a crusade so we are going to go on a crusade together on this. But we are povertizing a lot of Americans to get them into the Medicaid program because they are elderly, disabled by a chronic illness, and we shouldn't do that. Let them stay in the Medicare program, now that we are getting some

economies into it, and leave the Medicaid program just for the working age poor.

Then I think the states and local government could find some creative ways to handle that one, and to help them out, I always use to oppose a Federal tax on cigarettes because I thought states ought to do that. It is a great way for states to raise money, but I finally changed my mind, and I am going to propose one of these days a rather large Federal tax, all of which goes into indigent wellness, preventive care, all that sort of thing.

A lot of it is going to go into maternal child health because all of these preemies, these very expensive preemies, don't have to be that expensive. I mean, the womb is still the best incubator of all if we could just put a few dollars into educating some of these new mothers on nutrition and a whole lot of other things. But the dollars aren't there. The dollars have to get spent in the neonatal intensive care unit. We haven't got them to put into some of these other things. So I am going to propose that we use the cigarette tax to do that and a lot of other related things.

VOICE: One other question. Something that is of concern to all internists is the idea of capitation which is what Medicare is talking about now also, and the problem with capitation in terms of taking care of the elderly sick

is that all the incentives -- you Republicans are interested in a free market -- all the incentives are with capitation is to not take care of the sick, only to take care of the well, because they never come in and ycu get paid anyway.

It is six or eight dollars a month, and there is going to be a great incentive among primary care doctors like everybody in this room to not take care of people who are going to be sick; only to take care of those who are going to be well. What kind of -- what do you think can be done to the system to make sure that that doesn't occur?

SENATOR DURENBERGER: Well, the design of the competitive medical plans for Medicare patients is supposed to, or eventually will as it is modified, anticipate that sort of thing. Even the well eventually get sick so the question is, if you want to skim or do adverse selection and just take well people in the beginning, eventually it is going to catch up with you, and just like the experiments in the Twin Cities and other places show, there is a certain amount of adverse selection going on.

But I think we are learning now as we watch the competitive medical plans process start to take effect that if we do the reimbursement part of it right, and we have a few other guidelines and so forth that we build into the process, that as long as there is a competitive market out there between those plans, that we think we can minimize the

adverse selection so that everybody is going to end up with some sick and some well and some in transition.

VOICE: My question is what will you be doing in this session or maybe the next at the Federal level to encourage selection of and development of HMOs or alternative care delivery systems. If you could just say a specific word more about your systems as you see them?

SENATOR DURENBERGER: Yes. All we are doing now, I guess I have never made any bones about the fact that I think the Government ought to get out of the insurance business and just use vouchers for Medicare and for Medicaid, and I illustrated that here a little earlier. The competitive medical plan experiment with Medicare patients is supposed to give us the learning curve on which to do that.

Hopefully, eventually what we will do is pay everyone's choice of a health plan a dollar amount based on their age, sex, previous health condition, and the average community cost of health care. So your mother makes a selection of a plan, and depending on those four factors, we will pay a dollar amount to that plan.

VOICE: It would be community --

SENATOR DURENBERGER: That is right; different from community to community and she can get in or out of that plan every year just like you do at the FHBP here. She

can buy more coverage. We can get rid of Medigap and Supplemental very easily with this way because she can buy whatever she wants to buy, and depending upon what I am willing to pay, she will have a larger or smaller deductible or she will have some other form of cost sharing, so all she has to do is make one buy. My folks sit down in Florida now, most of the year, pay $76 a month each of them for a supplemental plan, and they don't get sick. They are wasting -- I don't know, between them, it must be a couple of thousand dollars a year that they could use for some cost sharing if they knew they just had one plan.

But they get their Medicare plan, and then they buy this supplemental because some old movie actor on television tells them they have got to buy this supplemental.

VOICE: It is Reagan.

SENATOR DURENBERGER: Yes, Reagan. I didn't mean him. No, no.

(Laughter.)

SENATOR DURENBERGER: These other, these still active actors are all on television selling the old folks these plans, and they are wasting $76 a month each to buy this protection they don't need. If we put catastrophic in there for them, and then let them use their voucher to buy these health plans, they would be so much better of.

We also need to do continuity on private plans. This helps some of the problems with the indigent. Now that we have the tax subsidy for the fringe benefits for health care, we ought to insist that we get something for that. Continuity means that if there is a death in the family or a divorce or something like that of the employer or the employee, the survivor spouse, children, so forth, ought to be able to buy into that health plan for some period of time at the same rate as the group. There are other things like that that you can do also.

Yes?

VOICE: It seems to me -- you mentioned that you are changing the way health care is bought and delivered, but you are also changing health care and the quality of care because what you are talking about, under Medicare, at least, is a volume driven system. You have said, "We will pay X for such-and-such an illness" by a very broad region of the country.

To use a simple analogy, let's say the Government wants to buy desks and says, "Well, everyone over a certain age or who fits a certain category is entitled to a desk, and we will pay $300 towards a desk." Well, some people may buy the $300 desk. Some people may take the $300 and buy a $200 desk, pocket the difference. Some people may decide that a $3,000 desk is really what they need and pay the

difference.

That is very different from saying to all the people who make desks, "You must supply everyone under this program with a desk for $300." Now, it is true that among that group some people will probably supply a functional desk which will meet the needs of some of the people, but it won't meet the needs of all the people. As you have structured it now, you are denying anyone who wishes to allocate more resources, which you may find an absurd proposition, you are denying them the right to allocate those resources as Medicare right now, since 1984, Deficit Reduction Act, is structured because as internists, for example, we are forced to in some way cut back on something we do, and I am referring in particular to the issue of professional interpretation where acknowledging that fee structures are a patchwork of historic antecedent. A substantial portion for many internists of their revenues come from what some call a mark-up and what we call interpretation -- raw material, namely, uninterpreted data that comes back to us.

In so doing we are at this point cutting back, and you are saying you must deliver. You are saying to the hospitals here, "You must deliver the desk for $300." I don't think you are going to get the same desk as much as everyone would like to. In my particular practice, were I

to have, at this point to accept in totality Medicare allocations, I would just meet the overhead for my practice.

You might say, "Well, then, there is something wrong with your practice," and yet when you talk about choice, you have 60 percent of Medicare claims being accepted on assignment. Surely the people who come recognize some characteristic that they wish or value, let's say, and are willing to pay for.

I think you are going to get a volume driven steel desk, and just as some nights you may go to Scholl's Cafeteria for dinner. Some nights you may go to Dominique's. The nutrition may or may not be the same, but the satisfaction you get, the emotional support you get by being known by the waiter at Dominique's or wherever it might be, is something that may be valued, and I think health care, it is not like stamping out fenders. It is not like putting out a certain volume of chemicals, and if we are forced to volume deliver which is what is really happening, I think, a lot of the human aspects will have to go.

I mean, I won't be able to provide services in a downtown location in a quiet setting with close to an hour for a physical exam. I can't do it. You are saying that is not something that Medicare beneficiaries will be able to buy.

SENATOR DURENBERGER: Let me tell you, I don't disagree with anything you said, nothing. The question is, how do you get to the ideal world with the downtown setting and the shady trees and the what not? And you are going to have to get there eventually through consumer choice. We haven't provided that yet because we have basically, we have substituted a totally unregulated cost base reimbursement system we have gotten rid of, and we have substituted kind of a regulatory system.

You know, everything is $300. Every desk is $300; your example.

But while doing that we have acknowledged a couple of things. Number one, if we had a severity index to go with it, then the desk wouldn't be the good example but something else might be a better example. A severity index would add a little heart to this process. We don't have it so what have we done?

We have, in effect, said, "We will pay you $350 for that desk, and if it is in certain parts of the country we will pay you $450, and if it is in the city as opposed to the country we will pay you $500. We have done that artificial sort of thing, but we have always acknowledged that this prospective payment system for hospitals is not reflective of the way either medicine should be practiced or people should buy it.

But what it does, first, it is temporary; and secondly, it makes the deliverer think in terms of X number of dollars to spend, and if they can do it for less and deliver on the quality, they ought to be able to do it.

Now, that is going to be replaced by the competitive medical plan where the arrangement, then, is when I go in and buy my plan, I can buy whatever I am willing to pay for as an add-on to that plan -- gives me some of those other choices. That is what a voucher in Medicare or a voucher like we have in the Federal Employee Health Benefit plan will eventually give you.

VOICE: Are you aware, though, that as this law of '84 is interpreted by HCVA now, it represents a substantial rollback of charges with regard to internists and in particular --

SENATOR DURENBERGER: Oh, yes.

VOICE: -- the subject of professional --

SENATOR DURENBERGER: Right, right.

VOICE: Because in the law --

SENATOR DURENBERGER: The cognitive -- yes.

VOICE: That is the basis for the rollback because this was supposed to be a freeze among other things.

SENATOR DURENBERGER: That was done by Congress and the -- yes, and I never -- won't be able to defend what we did. What we are trying to do now is to press HCVA to

come up with a position component, now that we have had two years of Part B freeze, trying to push them to come up with a position component that is prospective also.

We have looked at all the data, and if you read -- it is all in the latest issue of the New England Journal, I think. If you look at the data, just adding a position component to the hospital DRG doesn't look like it makes a hell of a lot of sense, so it looks like we will be moving in the direction of the relative value scale, and in that, if you look at all, internal medicine, you are going to find a combination of the cognitive and everything else. And so you will be able to come up with a prospective payment -- we will be able to come up with some kind of a prospective payment system for internal medicine that will be different from a variety of other professions.

But we will be able to incorporate that so-called cognitive aspect into the payment system because we will structure the payment system different for different -- supposedly that is the direction we are headed.

I think, while you are absolutely right in your characterization of everything as it lays out there in the '84, '85 timeframe, that the direction we are headed is in the direction of more individuality.

VOICE: I think we should take it to a close because you have got a personal life, as do we.

Thank you.

SENATOR DURENBERGER: Thank you all very much.

(Applause.)

(End Tape 1, Side 1.)

TRANSCRIPT OF PROCEEDINGS

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Medicine for 21st Century Economics

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The Honorable Dave Durenberger & Panel

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EX. 213

PANEL DISCUSSION

DR. BOYLE: Senator, I heard another statement recently that might go along with some of your remarks; someone who said that where you stand depends upon where you sit.

(LAUGHTER)

DR. BOYLE: I promise not to carry any of those remarks back to Minnesota.

We are now joined by a very distinguished panel. I am not going to spend the remainder of this hour in introducing them, because to recount all of their accomplishments and positions would take precisely that long.

But very briefly, we have with us Dr. Arnold Brown, who is dean of the University of Wisconsin Medical School, from the University of Wisconsin, Madison; professor of pathology, chairman of the council of deans of the Association of American Medical Colleges.

Dr. Theodore Cooper, who is vice-chairman of the board of Upjohn Company. He has been professor of surgery

and pharmacology in no fewer than four different universities, and has been known best perhaps as the Assistant Secretary for Health in the Department of Health, Education, and Welfare, 1975 to 1977.

And Dr. Merrill Werbloom (Phonetic), who is the professor and chairman of the department of family medicine from San Bernardino County Medical Center. He has been distinguished by being the recipient of the second annual Barbara Harris Memorial Award in 1985 from the California Academy of Family Practice, an award given to the physician-educator who has contributed to the most to the advancement of family medicine in California.

I'd like Dr. Brown, Dr. Cooper, and Dr. Werbloom to respond in five minutes, approximately, apiece, to Senator Durenberger's remarks. And then, let us have a lively conversation, all of us.

We'll begin with Dr. Brown.

DR. BROWN: Thank you. And it's a pleasure to acknowledge the talent of our sister or neighbor state. One of our prime preoccupations in Wisconsin is to make Minnesota look better, and in this case you've done very well.

SENATOR DURENBERGER: Thank you.

DR. BROWN: You're welcome.

(LAUGHTER)

DR. BROWN: They beat us in a double-header in hockey a month or so ago.

I'd like to respond more or less on behalf of medical education, a preoccupation of mine, and to address myself to two points that the Senator made.

I must say that the theory of economic -- or the expectationist economy, is that how it was put? I suppose that a fairly large segment of the population has rising expectations. But those of us in medical education are not disposed to share that feeling. Our expectations are one of a declining share of the economic pie in the country for a variety of reasons, some of which I'll return to in a moment.

But the basis for those expectations, declining expectations, rests on the second point, or another point that you made, Senator, in regard to the fact that you have to start living within our means. And if that means the participation of the various governments in this country in the support of medical care, then that certainly will decrease the proportion of funds in medical education.

We've heard earlier this morning that we can expect perhaps a leveling-off of support for the National Institutes of Health. The effect of this on the biomedical research enterprise obviously is important, but I suspect that if the deficit reduction legislation remains in force,

that NIH's reductions will be significant. The effect of this on the biomedical aspects of our medical schools will be also significant.

I should mention that, as far as patient care is concerned, we in the medical schools, just as physicians more generally, believe that the support that we've received in times past through a variety of mechanisms will decrease. And in medical education itself, we can, I think, assume that the future holds for us, by the turn of the century, that our medical schools will be smaller in several respects: smaller in terms of the numbers of students that we will be educating, smaller in terms of the numbers of faculty that will be engaged in medical education, and adaptation to a decline in the support for medical education more generally.

The Senator has been very active in his attention toward the funding of graduate medical education, another part of the continuum of medical education. How that's going to turn out is going to be interesting, Senator. And I would be -- well, I won't predict how that will turn into the year 2000; but perhaps you'll comment on that, as well.

PARTICIPANT: Well, Boyle has already broken through the defense on that for the internists.

DR. BROWN: That's all I have, Joe.

DR. BOYLE: Dr. Cooper.

DR. COOPER: Thank you.

As I understand it, the task at hand is really not to represent the pharmaceutical industry; but I would say categorically that I'm confident that they will be all right in the 21st century.

(LAUGHTER)

DR. COOPER: They're going to be all right because of the things you hear in the first session. So I won't dwell on that.

But I think my job is to act like a futurologist and an economist, but not as a Senator. And that's a terrific opportunity, because as a futurologist and as an economist, as you know, you're never held accountable, and you don't have to be understandable, and you certainly won't be held liable, I don't think.

(LAUGHTER)

DR. COOPER: And it seems to me that in an interesting way, about the rising expectations, it called to mind that I would guess that there have been two schools of economic thought that have shaped health policy in recent times, and they may be characterized best as the Mae West school and as the Marie Antoinette school.

Now, for about the past 50 years, at least since 1975, as the Senator has said, we've had the Mae West philosophy as prevailing; and that is, that too much of a

good thing -- is wonderful.

(LAUGHTER)

DR. COOPER: But the interesting thing is that -- the prevailing idea was that health was important, it was top priority; that medical care should be better; that everyone should get it; and that everyone should get the best medical care.

And what we are now seeing is an important change, irrespective of whether it's the "great communicator" that's riding herd on it, or his predecessor -- and it did start back some time prior to the current Administration -- and that would be the Marie Antoinette approach, which is essentially, "Let them eat cake," you know.

In other words, that health is no longer top priority. In other words, the United States of America cannot afford better care for everyone, and therefore we should treat fewer people with fewer physicians and fewer and smaller facilities, and most importantly, I think, that everyone doesn't need the best.

We used to use "best" with the words like "excellence," and "quality." And up until the present time, we haven't touched on the relationship of quality to economics, because in the current thinking, quality I think is equated with a deviation from the average, not from a

goal of excellence.

Since we've let economists and economic thought drive health policy so strongly in recent years, it's clear that we are about to let market forces select who shall be in the treated cohort, and who shall receive the best care.

Now, the illusion is that free enterprise is what will lead the system successfully into the 21st century, and that includes taking care of yourself and self-reliance and so on, and also an interesting concept that has dominated meetings such as this, I think, the word "competition." And it's not for professional performance but fiscal performance, or price competition.

However, labels aside, it seems to me that we're moving inexorably toward a nationalized type of medical care system for the 21st century. I would put that on the table. It's not a shot at the government, because I have great affection for it -- some of my best friends are in the government.

But if you look and you see the trends, what you'll see is fees and prices will be regulated, professional standards are or will be imposed by the government, the manpower pool will be fashioned and regulated by the government, a policing system by government or closely surrogate bureaucratic entities will ensure compliance at great cost.

Rewards will be, and are even now, increasingly given for doing less. And the focus will be -- the margin or the profit will be individual incentive, will be to increase your margin, not to do more. And there will be books in the 21st century or before on how to beat that system.

And then, with some embarrassment, but not much, we will restructure a multi-class nationalized system of care to finally sweep the problem of care of the indigent under the political rug.

Now, unless this is the scenario we truly want, we had best slow down our drive to practice medicine by economics, and with some degree of increased courage, including political courage, we should ask the hard questions out loud like, who is responsible for the care of the indigent? Because there will be people, even with knowledge, even with knowing about personal responsibility, that will not do the right things. And this society will not abandon them, and somebody will pay for it.

How much, then, are we willing to spend on health care? Now, economists like to set goals, and I think we should start with the question, what percent of GNP is right for Americans to allocate to the care of their health? Or, what can we afford?

DR. BOYLE: Thank you very much, Ted.

Dr. Werbloom.

DR. WERBLOOM: Thank you.

I would like to use the Senator's remarks more as a stimulus to myself, to focus on the practice of medicine for the 21st century, as affected by economics, rather than respond to anything he said directly.

It's my feeling that the effect of economics on the practice of medicine for the 21st century is here and now, not 15 or 16 years from now. But let's think back a little bit that what we've been faced with, in simplistic terms, has been that similar to if all of us were afforded the opportunity through our employment that every three years our insurance would guarantee us a new $10,000 automobile, there are two things or three things I think we could agree upon.

One is that every three years most of us would get a new automobile. The other is that Detroit would probably not make a car that costs less than $10,000. And that has been the consumer approach ever since Medicare and Medicaid were passed.

Now, the physician's approach, the practicing physician's approach, has been to increase fees whenever there was a need to increase income. And that's how we have spiraled.

Now, earlier this morning we heard -- and thank

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God we heard -- that the science of medicine will continue to expand, and the technology will continue to expand, and the technology will cost more money. We also are faced with the fact that the dollar available for continued support of basic science and clinical research perhaps will not grow.

We also know that there is a subcommittee in Washington that is looking at the support that medical schools and residency programs get through Medicare dollars, and there will be an effect there of some kind or another.

But we also know that the practicing physician is faced with a major changing environment. There is competition today in the market place; there is not competition planned for 15 years from now, there is competition today in the market place.

There is no doubt that networking exists in the market place today. There is no doubt that there is a move, and will be a continuing move, toward prospective payment for health care, both in the hospital and by physicians. There are those who say that 40 percent of the population y the 1990s will be covered by some form of capitated pre-paid plan.

There are those who also say that private industry in the health care system will control many beds, or that most physicians might work for a small number of national corporations. These are all with us today. And I

speak neither for nor against at this point any of these forces, but they exist today.

For medicine to survive in the 21st century, we need to include the approach to providing the practicing physician with an understanding and tools for that physician to survive in the economics. This then brings us back to, where does the practice of medicine begin?

I know that some of you may say that the practice of medicine begins in the laboratory, and to an extent that can be argued. There are others who might say that the practice of medicine really begins after residency training, and that may be true for some. But the practice of medicine actually begins within our medical education system. And unless the physicians of the 21st century can understand their role in the environment that we will hear about for three days, the practice of medicine may not survive in the 21st century.

So we need to talk about the integration within medical education of all the forces of economics, as well as the other issues we will hear about in the next two to three days. I hope we spend some time on that, because we cannot focus on the bottom medical issues of delivering health care to people and ignore the psychosocial and economic issues, or ignore the ethical issues.

We cannot afford to forget that medicine is a

science which is applied to a very intricate and complex living animal which responds to its environment and to other forces beyond that which science can measure.

DR. BOYLE: Thank you very much.

Unfortunately, Senator Durenberger must leave us in about four minutes. We have an opportunity I guess to ask him one brief question. However, he left something up here for me to make certain you're aware of, and that is a publication written by Senator David Durenberger, called Neither Madmen Nor Messiahs.

One of his other obligations is serving as the Chairman of the Senate Select Committee on Intelligence, which is what will carry him away. I presume there is a great deal of that problem in here -- is that correct, Dave?

Now, he didn't ask me to tell you, go out and buy one. But if you would, it wouldn't bother him.

SENATOR DURENBERGER: Now, I've got to give you five years on internists.

(LAUGHTER)

DR. BOYLE: We did pretty good.

SENATOR DURENBERGER: I know you did.

DR. BOYLE: Well, that's an appropriate question, Dave.

You have made the observation that we are going to have to pay for what we get, everybody is going to have

to assume their own responsibilities. Is it a part of your own personal view that, by getting the government out of financing various parts of education, research, graduate medical education, medical schools, that that is the way you're going to accomplish this?

SENATOR DURENBERGER: No.

DR. BOYLE: Or, is it appropriate to use a budget process to change a process of medical education that has evolved over a century?

SENATOR DURENBERGER: The theory is very simply that there is no market place in medical education, unless -- you could get a market place real quick if everybody got out of the third party financing and you just left it to the rich kids to go to medical school. You could get a market place real fast.

Now, we were getting to that point. Knowing that this deficit and the failure to cut spending is coming along, those of us who feel that this ought to be a shared obligation to make sure that there's a fair market out there said that Medicare as an insurer ought to make a commitment to finance a part of graduate medical education.

So the positive way to look at Dole-Durenberger-Bentsen is to say that we made a commitment of a billion dollars a year out of the Medicare trust fund to finance a bunch of medical schools and the graduate medical education.

We tried to set some lines about how far we would go, so that the market on some specialties would work over that.

Also, we thought that would be an example to Blue Cross and other third party payers, that they ought to pick up some portion but not a free check through the cross-subsidies, on how to finance it.

And thirdly, as you pointed out, there ought to be some example to the Bostons and the New Yorks and the Houstons and the Twin Cities that, if they want to brag about being "medical alley," and they've got all these tremendous medical schools there, by God, they ought to start paying for it. They ought to dig up a little scratch in the Twin Cities, or wherever, to help pay for this medical education, without pushing it off on the consumer, or on Medicare and the other third party payers.

DR. BROWN: If you need any help up there, we'll be glad to come up from Wisconsin and tell you how to do things.

(LAUGHTER)

DR. BOYLE: It is time. Dave.

SENATOR DURENBERGER: It's 11:30. I've got a 12:05 flight to L.A. Is there one question I could take?

DR. BOYLE: They tell me, you'd best make like Cinderella.

SENATOR DURENBERGER: Okay.

(APPLAUSE)

DR. BOYLE: Fine. Thank you.

All right. We have three experts remaining. Who has a comment or a question?

Yes, sir. Would you please give us your name? I think, if you sit where you are and simply project your voice forward, it will be heard.

MR. MOTOLSKI: I'm Arnold Motolski of the University of Washington.

I'd like to ask the panel, and particularly Dr. Brown, about the possibility of what's happening in medical schools in relation to a two-tier kind of medical education; in the sense that the research-oriented medical schools are getting money and more money from the NIH, and that probably is going to continue, but because priority scores are going to be more and more difficult to get, many other schools will not be able to carry out research. So that the idea of medical schools of 15 years ago, that every school would have a research establishment, is going to go down.

What is this likely going to do to the kind of doctors that are going to be treated in the two kinds of schools that might be foreseen? Does it mean that we're going to have one kind of doctor who is more intellectual, scientific, specialty-oriented, and another kind of doctor,

and maybe more women coming in, who are more service-oriented and have fewer of the interests that the current modal doctor has? What will that mean for medicine of the 21st century? Or, is my prognosis wrong?

DR. BROWN: I suspect it's wrong.

The problem of the so-called two-tiered education certainly is one that's been a matter of concern for a long time. And it is true that -- and I can't give you the numbers, but it's true that the bulk of NIH-funded research is concentrated in a smaller, in a relatively small segment of the total number of medical schools.

But the effect of that -- and I suspect that over time that the effect of that will not change, that the relative proportion of funds as distributed among the medical schools will remain reasonably constant.

But I don't believe that over the long term that's going to change much the kinds of people that we are able to attract to medicine. And I certainly don't agree with your point that, with the increasing number of women that are coming into medicine, that that will change significantly the proportion of our students who take up biomedical research.

I guess my problem -- or that is, if I stay with my predictions that the number of medical students that we will be educating in the year 2000 will be probably four or

five thousand less than we are today, and that medical education generally will have a smaller budget, I see us decreasing, but that the proportion of people that we are able to convince to go into biomedical research proportionately will be roughly the same.

This question was raised in the earlier discussion on science. At the break we were talking about this, and the difficulty that we have in making attractive enough biomedical education, or biomedical research rather; and the issue of, golly, it's costing so much now to be a physician that this has diminished the allure, or the possibility rather of taking extra work, fellowships, getting extra degrees.

But I don't think proportionately that's going to change. The two-tier system, if you wish to call it that, that we have in effect now, will likely remain.

DR. BOYLE: Ted Cooper, you said that we should decide how much of the GNP is right. Do you mean we ought to pick a number?

DR. COOPER: Why not? You could say it's wrong now. If it's wrong now, what should it be? I mean, if the Senator were here, that's what I'd ask him.

If spending whatever it is, 10 or 11 percent of the GNP, is a bad thing, what's right, 8, 9, 15?

DR. BOYLE: Well, who says it's bad? That's the

question.

DR. COOPER: Oh, that's what the implication is. And some people actually say, "We should not spend that much money." And I think there's no reason to think that. And I would think that one ought to pursue with some thoughtfulness an adequate commitment to reach a certain proportion of resources to go through the entire enterprise.

DR. BROWN: Don't you think that's a more rational exercise than one can expect from even this group, but certainly the Congress of the United States?

DR. COOPER: You mean this group?

DR. BROWN: This group, which I regard as a rational bunch of human beings.

DR. COOPER: I see. I think it's no less rational than some of the mickey-mouse in those bills that he was talking about, about how to arrive at what number of people, and all that sort of thing.

DR. BROWN: No, my point is that, to come up with a number is a very rational act, more rational than I suspect that the Congress is capable of doing, or even this group is capable of doing. To get agreement, be it 8 percent, 12 percent, or whatever, would, I suspect, be an impossible exercise.

DR. COOPER: Well, there are throughout many areas of American enterprise in the economic United States -

- the business is done by setting such goals. Even the Congress periodically sets themselves some goals, including this wonderful Gramm-Rudman thing that has absolute goals in it, year by year.

And I'm not sure that it'll work, and he may be correct that Gramm-Rudman will fall of its own weight and they'll have to rescind it; but it would be a much more logical process, I would think, for them to pursue national health policy with the recognition of what all the factors are, and what all the needs are. And if they want us to live within our means, put some dimension on the means that we can reach and we can therefore plan cohesively and stop the conflict between, are we spending too much on research and not enough on social issues?

If you put them all on the table, lay out what the policy should be. Then you can say, "This is likely to cost a certain number." And then you can reach a decision nationally if in fact we can afford it. And I think that's rational.

DR. BOYLE: One of the issues that has been touched upon is the relative size of medical school faculties. There has been some criticism of U.S. schools, in that there are many more faculty-to-students than there are in some other countries in the world.

Dr. Brown says there is going to be a smaller

faculty. How do the other educators in the group here feel about that? What are your views?

It's very difficult to see with this light here, I'm sorry. Yes.

PARTICIPANT: Well, I happen to come from a view that says the size of a medical school faculty bears little relationshi to the number of students taught. And that's because our faculty sizes are driven from other forces. One is the size of the research enterprise, of course. And the second in the current era is in the size of the service enterprise, the organized faculty of medicine in behalf of the academic centers.

So I would not necessarily agree that a decrease, a relatively small decrease, in the number of medical students in our schools will be accompanied by a decrease in our faculty size. I think there may be other forces that modify faculty size, but it's not necessarily the medical student complement.

DR. BROWN: Well, I should make the point here that I agree that faculty number is not a straight-line relation, or doesn't have a straight-line relation with the number of students. But the economic forces and the other forces that are acting upon us will have a combined result not only of reducing the number of students, but also the number of faculty.

PARTICIPANT: I suspect the state-supported schools are at more risk to have that line of logic imposed upon them when the legislatures mandate reductions in the enrollment. There might be an expectation that there would be some modification in the size of the faculty (Inaudible).

DR. BOYLE: I have heard that.

Yes.

DR. ROTH: Russell Roth, University of Washington.

We've heard today that our medical enterprise is based on our research enterprise, particularly our basic research. And we heard very eloquently earlier today that we probably would not have a burgeoning biotechnology industry were it not for the advances that preceded that, that were funded by the NIH.

Now, we're faced with Gramm-Rudman. Assuming Gramm-Rudman is found to be constitutional -- which I personally hope it's not -- but assuming it is, how is this going to impact on continuing support of biomedical research, and perhaps equally important on continuing support of training of individuals, both physician and non-physician individuals for biomedical research?

And obviously, our medical schools are very dependent upon this biomedical research support for their continuing ability to maintain themselves. How is Gramm-

Rudman going to affect all of this, and what do you think should happen if Gramm-Rudman is found not to be constitutional?

DR. BROWN: Well, anyone who says Gramm-Rudman is not going to affect us all in a variety of ways, but including NIH, and therefore as I mentioned earlier the biomedical enterprise, has just not read the law, nor looked at the incredible slope of the lines here.

If you had this hand-out, look at the negative slope of the line labelled Gramm-Rudman. I don't know what that translates into as far as NIH support, or NSF, but it certainly is a significant reduction.

So if Gramm-Rudman is with us, we're going to have a real tough time, unless of course, in the event that taxes are increased to cover the deficits in another way.

DR. BOYLE: Ted?

DR. COOPER: Yes. Two things. The allocations will not be uniform, and they will be the vested interests of various kinds that will do battle to ensure that in certain areas those cuts will not be what are anticipated by the authors of the legislation.

It is for that reason, I'm sure, that the Senator said by 1988 it'll be down the drain. That slope is viewed by many practical people knowledgeable in government budgeting and economics as a totally unachievable type of

objective.

It would be quite wrong, I would think, for this particular special interest to take the view that it is their job to sacrifice in the name of this important legislation, and that they should take a very big chunk of that right up front. You'll be in there, like we'll be in there, battling for exemptions, just like others already are. And whether or not it's constitutional will be irrelevant to its failure.

So I think the point is that the great American way is "make your case," and the great men in the Congress will decide on how to allocate the resources.

DR. WERBLOOM: I'd like to take a different point of view, for group discussion purposes. And that is, regardless of whether it's Gramm-Rudman or "X-Y-Z," let us hypothetically say that there is less money to support basic science research, for whatever reason. And let us take the position that we cannot say, "What are we going to do now? My goodness," and hold our heads. But perhaps we could generate some discussion on, how would we respond?

What could we do? How would the medical schools respond? What effect on faculty positions would there be? I don't know that I'm prepared to worry about what might happen, as much as I worry about, are we prepared to respond and not complain.

I throw that out to the group.

DR. BOYLE: Well, I'll say quickly, we sure as heck will complain.

(LAUGHTER)

DR. BOYLE: Yes?

MR. CALLAHAN: Daniel Callahan, from the Hastings Center.

You're touching on an issue that's become an important debate over the last couple of years, that Senator Durenberger touched on; namely, that if we can reduce inefficiencies, we can in fact get what we want.

On the one hand, you have Aaron Schwartz saying we really have to ration in this country. We have Marsha Angelle's (Phonetic) recent article in JAMA saying, if we simply reduce waste, we can perfectly well live within our means.

I'd like to hear the panelists comment on that debate. Do you think we can achieve quality medical care and at the same time reduce economic and other inefficiencies?

DR. BROWN: Could I add to that question? Make the assumption that there is going to be less money from the Federal Government, however you do it, because that's where they're going.

DR. WERBLOOM: Your question, if I heard it

right, was medical care.

MR. CALLAHAN: Let's say health care, health care very generally, since I assume the argument is that we spend a lot more than we need to spend at present on health care delivery, probably research, all across the board, and that greater efficiency will in fact achieve the same ends with no loss in quality. That, I take it, is the argument.

DR. WERBLOOM: I would respond with yes.

(LAUGHTER)

DR. WERBLOOM: And then, leave -- so you can't ask me how.

(LAUGHTER)

DR. WERBLOOM: But I do think there is some evidence that efficiency can be established in the delivery of health care services that can be protected in terms of quality, and can protect the indigent population and those who we will always have that will need services and can't pay for them themselves.

The problem -- and I've been involved in this for the last six years on a personal level -- the problem is, having the medical enterprise be willing, first, to accept that they may have to make changes in the way the practicing physician functions. And if behavior change is acceptable, then it becomes an educational issue of how to do it. In small pockets, it's successful; in large pockets, it's a

disaster -- so far.

But I think the direct answer to your question that I have to give is, yes. And I am not part of the medical school environment any longer, so I dare not answer the question of research -- although I have an opinion.

PANELIST: Could I take a crack at one aspect of that? The effect of efficiencies in the health care delivery system, as it affects education. I won't say it's the essence of education, but certainly a significant part of education, medical education certainly, is the fact that it requires a considerable inefficiency in order to be done well.

The physician who is assigned the third-year student obviously is not going to be seeing four patients an hour, may see one, if the time spent with that student is going to be at all useful to that student.

So the increase in efficiency that is being discussed and increasingly practiced in the medical environment is having, and will have, a very real effect on the quality of medical education.

DR. BOYLE: Ted?

DR. COOPER: I have a view, and a question for Dan back, or a question. The view is basically a "no," to the question.

The increased so-called efficiencies we're seeing

now with the incentives as currently constructed are not ensuring that the medically indigent are getting covered. In fact, there's an increase in the uncovered, if that's what the driving force is, efficiency. And the evidence that is available at the moment -- it is not theoretical -- is that it's working in the opposite direction, at least in part of the concept of quality of American medicine.

So I guess my question to you, Dan, would be, what do you mean by quality? I mean, it's interesting that it comes up. I'm delighted to hear it. But what are we talking about, "quality care"?

MR. CALLAHAN: I guess the simple response would be, with no loss in mortality or morbidity rates --

DR. COOPER: Outcome? Outcome?

MR. CALLAHAN: That the outcomes would basically remain the same. Great Britain has pretty good outcomes, spending a lot less --

DR. COOPER: You don't mean public health statistics as outcomes, do you?

MR. CALLAHAN: All right, I'll use that.

DR. COOPER: Well, that's a pretty soft one. Now today, what are the data on outcomes, before people make an assertion? We're hearing asserted, over and over, that you can make all these efficiencies and quality will not suffer. Secretary Heckler used to get up and say, "We got it down to

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single-digit inflation, and quality did not suffer." What's the data? Where are the data, rather -- or, what's the right English?

(LAUGHTER)

DR. COOPER: But whatever the point is, the answer, as data are available now, is "no."

DR. BOYLE: Yes?

DR. STONELAYER: I'd like to raise an issue before we're out of time about product liability.

DR. BOYLE: Could you identify yourself, please?

DR. STONELAYER: Oh, I'm sorry. Larry Stonelayer (Phonetic), a private practice obstetrician-gynecologist in California.

I think we're seeing -- when you see a person jumping off a pier in Newport Beach over a sign that said, "Do not dive or swim," suffering an accident, and collecting a multi-million dollar judgment against the municipality because the barrier wasn't high enough to keep him from climbing over it to hurt himself -- where we're seeing Bhopal and chemical industry problems, air tragedies; we're seeing a general pervasion throughout the economy about a perception of what product liability costs, the societal costs.

And as an obstetrician, the American College of Ob-Gyn says that one-third of us will be sued annually. And

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the attorneys tell us that that is because so many of us are bad, and our outcomes are bad, therefore they will punish us for our lack of performance.

And the medical educators -- the last time we're examined is when we pass our medical license examination and our specialty society examinations.

(Change In Tape)

PARTICIPANT: Is that going to be one of the costs we're going to have to pay to get no-fault liability insurance?

DR. COOPER: You're going to have to have that profile, whether you get no-fault insurance, or not. That's what is happening. Everything is being measured on the PRO system as a deviation from a norm, and that's a profile.

PARTICIPANT: But the numbers come from the side of the hospital provider in terms of length of stay and a diagnosis, but from the organized medicine side we don't have the numbers to prove what a good job we do. And we don't have those numbers to justify our expenditure of health care dollars.

Where do we get those solid dollars from our side, talking about the good job we do? Where do you get that data?

DR. COOPER: Well, you're going to have to invest in coming to a consensus, as Dr. Samon (Phonetic) said this

morning, on a variety of issues, one of which is, what's quality? What's quality performance? And then, what's a quality outcome? And then, get the data.

Now, the only major study that I'm aware of, in which outcomes are a specific target, is a large study being funded jointly by a few foundations and principally by the Robert Wood Johnson, on medical outcomes, comparing different systems of care delivery. Now, that's in process now. The methodology is difficult, and new.

But there is going to be no substitute for the profession to invest in finding out what it is they're about. And I think that that's if there is time before the system is nationalized.

DR. BOYLE: Yes, Jim.

PARTICIPANT: Yes, let me make one comment about the statement about no-fault liability. There are many of us that say a fervent prayer three times a say that we never have no-fault liability, with the firm belief that there is not enough money in the world to finance a no-fault professional liability program.

That's a debatable topic, and one that you can argue, but there are those of us who believe that no-fault automobile insurance -- the disaster that that has wrought in some places in the country is but a crack in the ice, compared to what no-fault liability would be.

But let me raise a question for you. Senator Durenberger in his projection through 1988 clearly has made an assumption that says that the level of defense spending is going to be maintained, the cuts in order to balance the budget or reduce the deficit are going to come from the social side.

Maybe Dave is right when he says that. Maybe it is a fact that the President can hold the position until 1988 on defense spending. But my view is that the next President of the United States, whomever that may be, is not going to have that high level of personal popularity that this one has; therefore, will not be able to replicate his ability to force the Congress to the position. And so from 1988 on, I really question whether the Senator's assumptions are correct.

And I suspect that what we will find is a change in the allocation of federal resources, beginning in 1990. And that in itself may change the impact on medical education, the impact on medical delivery, the impact on total health care in the country, far more than he's going to do with the mickey-mouse business of, first, certification eligibility of five years or whatever.

And it may very well be that your prediction about the reduction in medical school classes will come true, irrespective of the Federal Government. But I

challenge the assumption that we as a country will go to the year 2000 with the same percentage allocation of resources at the federal level that this President has been able to put in place and hold now for six years.

I'd like to know if any one of the three of you shares that point of view.

PARTICIPANT: You might note also, he predicts it's going to be Bush versus Hart, and Bush wins.

DR. BROWN: I suspect that the federal approach to budgeting revenues and expenditures will change in 1988, most certainly; that the hangover -- if that's the word -- or the state of mind that justifies a decrease in the total expenditures for health care, public and private, will remain through the end of the century.

So when I look at that from the point of view of medical education, I translate that then into a smaller piece of the pie, be it private in terms of patient care dollars, be it public from NIH or wherever. And I think that then a prudent dean of a medical school would project that out.

But the assumptions that the Senator uses I am sure will be wrong; that we'll have more taxes, that the internal budget decisions will be rather different after 1988.

DR. BOYLE: Bob Mosier (Phonetic).

MR. MOSIER: I'm Bob Mosier, from Philadelphia.

Ted, since you've put it on the table that you suspect there will be a nationalization of health care, how do you reconcile this with the prevailing view that most people are talking about -- Starr, Elwood, others -- that it won't be the government, it is going to be industry that will be the major pre-paid health care provider? How do you reconcile those two thoughts?

DR. COOPER: The management of the nationalized system might well be through a variety of financing mechanisms through employers, and managed by a private sector. But it will be all standardized, with the rules set by the government. That's what I mean by a nationalized system.

I don't mean that necessarily the Federal Government is going to do it out of general revenues. They don't do Medicare out of general revenues now, either. They don't do social security out of general revenues. But there are a variety of mechanisms available with which they'll increasingly do this.

But I agree with Jim and Arnold that, really, the premises will change. One of the interesting real numbers that you can expect, for example, will be that by the same time that someone mentioned this morning that there will be more deaths than births, the interesting thing will be more

people over 65 than under 25. And the people over that age group spend a lot more money on health care, and need a lot more money.

So there will be expansion of the system, and it's going to be preoccupation with regulation of that system, which will determine the nationalization aspect; but the financing of it will continue to expand inexorably.

MR. ABRAMS: Herb Abrams.

It seems to me as though there are two sets of facts which are really in opposition here, and which warrant a little more exploration. One of them is that the only way to cap the cost of health care is to cap it. And the British have shown us that, I think, without any question of a doubt. You put a figure on that fraction of the GNP, and there it is. And then, you must accept rationing, as they have accepted it, rationing of health care, for example, in terms of dialysis for individuals over the age of 60, cut it down to 60 percent, etcetera.

And then, against that stand the perceptions of the American public, as you survey them in every city in the country. At the top of the priority list is health care, or really second only to crime. And then you move down through education and housing and defense, and so on down the line. Health care, second only to crime.

And so it seems to me as though the question is,

how in this wealthiest country of them all, do you jell the perceptions of the public, and their demands, and their priorities, with this increasing pressure for a cap?

One important last point. That is that, when people have the choice between systems of health care, as they complain about the cost of the care, they still choose the most expensive one, because for one reason or another they think it's better.

PANELIST: Yes, easy. All you've got to do is, don't do like Britain and set that cap at 6 percent or 5 percent, set it at 15.

(LAUGHTER)

PARTICIPANT: Well, that's what Rhinehardt says.

PANELIST: That's right.

PARTICIPANT: And (Inaudible) is not here. He's ill, incidentally.

PANELIST: Well, if he were here, he would tell you exactly that.

DR. BOYLE: I am afraid we have come to the end of the hour. I have all kinds of hands out here. I suspect that this discussion was just heating up.

Well, let's hope it does continue for the next several days.

(APPLAUSE)

MODERATOR: Some quick housekeeping. If you will, you can make your way across the rotunda into the dining room. We're prepared to serve a very rapid lunch. The reason for the rapid lunch is, we want to get you tennis players and golfers over to the Marriott as near one o'clock as possible. The shuttle buses will begin operating at 12:30, so please make your way there. The hotel personnel will get you to the appropriate golf or tennis pros, so just ask them, they'll get you there.

Let me remind you that the ballroom entrance at the Marriott, the shuttle buses will begin operating to bring you back over at five o'clock, for the 5:30 session on public attitudes, which by the way these comments are an excellent bridge. I'm very excited about hearing Barbara Kaplan this afternoon in that session on public attitudes. So please be there assembled beginning at five o'clock, so we can begin on time at 5:30.

By the way, come dressed for the steak fry, if you'd like, informal. We prove that we have ties and coats. We do that here in the desert because people think that we don't have them.

Before you leave, I would like to introduce to you a very important person to us here, Ambassador Walter Annenberg.

Ambassador Annenberg, would you just stand.

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(APPLAUSE)

MODERATOR: Thank you so much.

Please now make your way to the dining room.

(END OF RECORDING)

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TRANSCRIPT OF PROCEEDINGS

Transcript of Copy of Tape Recording
Provided to the U.S. Senate Select Committee on Ethics
by Senator David Durenberger

March 18, 1986

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VOICE: -- that you will be patient with us over the next couple or three years.

First, in terms of my bona fide as to being here, what are you interested in? Well, we are heading for national security policy, might want to pick up a copy of a book I wrote. Actually, I wrote this in draft form for my constituents back in 1982 when I was running for reelection. A Marine, former Marine publisher saw it and convinced me I ought to put it in a book, but it is called (inaudible) and it is available at most B. Dalton Book Stores.

But it is a -- a strategy for developing national security policy. I am not doing that on the intelligence side, and Barry Goldwater, who read that from cover to cover the week it came up, and Sam Nunn are doing it on the Armed Services side, and eventually, maybe in a matter of four or five years we will have a national security policy in this country with a strategy that has a defense element to it; that has an intelligence element to it; and has a foreign policy element to it, and so forth.

The reason we are moving in that direction is for consistency and for focus and for efficiency in utilization of our dollars and in our other human, other kinds of

resources.

That is the same theory, I guess, that is behind health system reform, will eventually be behind reform of income security in the country when you tackle issues like retirement disability and you tackle issues of welfare reform and how a country puts a better safety net under its less advantaged.

Anyway, we are in the era of reform, having learned that there isn't any problem we can't solve in this country, we are now in the process of finding better ways to solve it but we won't spend the money on it, and right now that is the real revolution. It is not getting government out of domestic services and it is not getting the national government out and dumping everything on the state. It is finding better ways and better combinations for financing these public services in general.

The President talks, as you know, about private sector initiative and all that sort of thing. What he is saying, I think, when he does that -- I am not sure he understands fully, but probably better than a lot of other people do. What he is saying, in effect, because with some rare exceptions there aren't any services in this country that can't be produced by a for-profit institution of some kind.

We have created the non-profit institutions in

this country as a way to subsidize certain kinds of services in the way we have created government to subsidize certain kinds of services that the for-profit system couldn't deliver. But that doesn't make profit bad. It just makes it less of a subsidy. The risk -- is not as available in the for-profit sector as it has been in the public sector.

But that is only because we have been reaching for -- intentionally reaching for a new way to do this and a new way to do that, and while there is a certain amount of risk taking in the so-called private sector, private goods and services, there has never been enough risk taking in health, education, welfare, and so forth, other than in the employee fringe benefit area, so that we could ever do without the non-profit corporations or the government.

Now, I would argue that the non-profit corporation's days are numbered in America. Some day I will find the time to write that up someplace so people can laugh at it, but it is a question that is very appropriate for you to think about in that context and try to be helpful because I presume without knowing that that issue is the essence of why you are going into the long-term care business.

You have the precedent of proprietary and non-proprietary so that there would be some encouragement that you could come in, and if you were good, that you could make some money. But the reality is that there is no, any

longer, any reason for hiding subsidies under the aegis of (inaudible) 1(c)(3) for most public services.

Institutions that in an era in which value and efficiency are wrapped together, trying to save money and also deliver a quality product, in that kind of an era there really is no longer any reason for hiding the subsidy. Subsidies really ought to be as explicit as possible so people can shift them from one institution to another.

So the only way to do that in just a corporate arrangement is to get rid of the notion of the non-profit corporation to provide something like long-term care, to stick with your example for the sake of debate.

Now, you may want to say that shelter services for the elderly is a public burden; or that certain kinds of health care for the elderly is a public burden. Okay, and we would like to subsidize the access to that to make sure that there is enough shelter around, that there is enough service around.

The question is, would you if you were starting from scratch in 1986, would you start the process by creating an open invitation, "Anybody that wants to go into the 501(c)(3) rest home business, to do that." Or would you say, "I am going to provide every person in this country over such-and-such an age with such-and-such a condition with a dollar denominated right to make a choice of this set

of services."

I would choose the latter for the same reason that I would do that when I buy automobile glass or containers for beverages or anything else. I would find a marketplace by empowering the consumer to make the decision. I don't get to a marketplace by giving all my money to providers and saying, "Anybody who wants to go into the glass bottle business gets to go into the glass bottle business, and we offer such a subsidy to do it."

Where the hell did we ever get the efficiencies out of that kind of a system?

So the same theories apply in any denominated set of public services. I mean, we are doing it all over the place now, from garbage collection to food service management, anything. You can do it in education. You can do it everywhere. There is no reason -- as long as you look at it in terms of who should get the money, and where should the subsidies be.

You can't tell I am a great believer in consumer financing, consumer choice in the delivery of services, and when I am given my druthers of where, how I take a subsidy dollar and put it into the system to get efficiency, I give it to the consumer.

John Brademus, the former Congressman, the president of NYU, was in to see me the other day on taxing

and bond financing. He was complaining that the way I have structured the revenues to taxes and bond financing, that I am making it difficult for him at NYU because they have such a small endowment and they take care of all these low income people and all that sort of thing, and that I should free him up to get as much tax-exempt bond financing as he could possibly get. I have a cap on it that no institution should be able to have more than $150 million in tax exempt bond finance out of any one tax, tax exempt finance bonds.

He thinks that will discriminate against NYU. Every private college in the country is discriminated. I said, "John, if I were going to use a 35 percent subsidy and $150 million worth of bonds, figure it out, whatever it is, $50 million or $60 million in subsidy," I said, "I wouldn't give it to you. I would give it to those poor kids in New York and let them decide whether they are going to NYU or CCNY or other places." And he said, "I have only got a $19,000 per student endowment, and CCNY, or whatever it is, has a $30,000, and Harvard has a $2.6 million, et cetera. You put me at a disadvantage."

I said, "So what?" I said, "I am not in the business of preserving NYU," any more than I should be in the business of preserving, you know, outdated nursing homes because they are owned by some little town, or even the public general hospital in those towns. Why should I

preserve a hospital just because it is here if somebody else can go into the service delivery business providing a lower price?"

Now, there are arguments you can make about transition and things like that, but that is just for facilitating your understanding of how I feel about the choices of subsidy.

You can take the notion of subsidy, and you can take it into a lot of areas of tax reform. Hard to deal with right now -- and into a lot of other areas.

But just for purposes of discussion of whether you should be in the long term care business, what kind of service should you deliver, and what is your competition going to look like, I would argue that as we move to greater consumer financing and we move away from institutional financing, we will start paying for outcomes rather than paying for the specifications; rather than specifying we want this, this, this, and this in terms of the way the place looks, the way it is manned and all that sort of thing. We are going to say, "We want outcomes. We will pay for outcomes. We will pay for satisfaction. We will pay for longevity. We will pay for, you know, these sorts of things. We are not going to tell you how to get there. We are going to pay you for the outcome."

And again there is precedent for that. We don't

tell people in the hospital, you know, how many CAT scans they have got to have and how many thises they ought to have and how many thats they ought to have, though to a degree the medical malpractice system beats them over the head if they don't have some of that, but I think we are going to move away from that as well.

We will pay for outcome, and I think, again, that is the way it is going. It will go that way in everything, including education and the way the concept of the public schools -- we will have public education, but I don't think we will have public schools by the time my grandchildren are going into the school system. I think the school system in this country will be private in the sense that they will be owned and institutions operating on behalf of a government called a school district, that they will be selling services to parents who are poor or who are whatever. It won't make any difference because it not only purports in where we are headed in acute care.

You can see that the voucher concepts, the competitive medical plan concepts, and all of that sort of thing, are built on a private market that operates with a broker called a health plan, and the broker does the buying of the goods and services on behalf of the consumer and competes with other brokers to get the business of those consumers, and if they don't buy the right facilities and

they don't buy the right providers, people are going to quit buying the health plan. That is how simple it is.

People will buy on the basis of price initially, but in the end they will be buying on the basis of satisfaction, and that same theory where everybody buys a health plan whether they are poor or they are employed or they are retired, they buy the same set of health plans.

That same thing is going to apply in education. There is no reason why people can't be good consumers of education. They may even be better consumers of education if they weren't forced to go to the little red box that happens to be within their so-called neighborhood. If they were able to have some choice and that choice came to the box rather than the kid having to go to the box -- already that operates on a college level, and I think it will operate at other levels as well.

On the long term care for extending this out, obviously, to the long term care where you are moving into a greater variety of social services, whether the chronically ill, the Jake Javits kind, in effect spending health care dollars for basic social services, or if the social service combination of shelter and nutrition and companionship and all that sort of thing. It is a big component of long term care.

The problem we have is that we don't have a

private health plan marketplace out there. We have private deliverers like you are, but we don't have private insurance or -- we just call it insurance. We call it health plan or something like that.

Why don't we have it? Because Government has the market all screwed up. Government pays so much to proprietary and so much to the non-profits and every state is a little bit different.

You have got state legislatures saying you can't go to any more nursing home beds. You have got the swing bed controversy. You have got all this crap going on out there. Who would want to go into the insurance business in order to do that? And yet we should.

We are putting our emphasis now on income security in this country. We are putting our emphasis on retirement, IRAs, Keoghs, 401(k)s, pensions, reform of social security -- I mean, all the emphasis is going to be on protecting people in financial protection in retirement.

At some point we will start cutting back on that because my generation got too much. It got a lot more than it needs by way of subsidized retirement and so on behalf of my children we are going to start cutting into my retirement and so forth.

But while we are doing that, we will hopefully, with the help of people like you, we will be creating -- and

we probably won't call it insurance, but it will be sort of a planned retirement programs which are already out on the market and you can see them in various forms; ways to use your income security or savings and so forth to buy potential social services that people need, including some of the nursing home based services.

So somewhere, and I don't know where this all comes out, but somewhere between the health care for acute care with the nursing home for rehab and all that sort of thing, and the nursing home as -- I keep using the nursing home in its larger context. It is really a shelter. I mean, it is like -- a hostel is a hotel with a specialized set of services. So is a nursing home a home or a hotel or something in between.

It is a shelter other than your own place, but there is nothing wrong with selling somebody a piece of a shelter if he wants it. I mean, the so-called Rembrandt and the rest of these guys -- "Give me your assets and I will give you a transition from a condo to an apartment to a snip to an ICF or something like that." I mean, they are all -- they are selling you a piece of the rock, if you can hang onto it until you get carried away.

So there are lots of creative ways in which we can all think about these things, whether it is for disabled people or whether it is for retirement.

The pressure on us now on ICFMR (inaudible). Sort of categorizing people. The way you get into an ICFMR is to have this condition. Once you are in there, we want to put you into a home, or a big one -- that is not the way people would choose care for their retired children.

And yet because we haven't understood that people's choices, there is some kind of an insurance protection that would make those choices for them, we are stuck with Government deciding, you know, "Here are the homes for the retarded." And Government always was in that business with big warehouses, and now we have downscaled that to community based services.

The next system is to just transist that into the private marketplace if you guys can run that kind of a business and know that there are people who when they are blessed with retirement children, also have the insurance protection to provide a set of services for them.

But until we, in the larger sense and the specific sense, are to get our act together in terms of how we are going to pay, or what role we are going to play, in paying for some of these long term care services, it is very hard for private insurance market to develop.

I really shouldn't talk much more than that about it.

VOICE: What do you see -- it seems to me that

the people who are offering insurance programs currently, in nursing home care, long term care, are basically selling that to those people who, in fact, probably could provide for themselves out of their private funds, and they are not attacking that segment of the population which your voucher system speaks to which says they are not attacking the segment of the population that, in fact, is going to be dependent on the Government for support when they get to be -- to require nursing home care.

VOICE: I think they are just like the Medicare supplemental folks. They are attacking my parents who don't need to buy catastrophic, or they don't need to buy insurance to cover their cost sharing. They would be much better off if they just paid their bills when they incurred them rather than being ripped off by these supplementals.

But unfortunately, you know, when you haven't got something else, the insurance market is going to go after whatever it can grab.

So I think that part of the problem here is that the insurance industry is so bad. I mean, I say this to them so I don't mind saying it to you. I mean, they just don't think creatively, and the Health Insurance Association of America is just Neanderthalish. It is just terrible, and I say that to them, too, and they get angry with me. But it is the truth.

There isn't enough gambling and creativity and so forth there to -- they should be pressing against us when we are doing tax reform. They came to us on tax reform -- you are missing something here. You know, there are things, there are ways, that you ought to structure savings and investment portfolios or whatever you want to call them so that people have some tax base flexibility that can have an insurance policy written against it. I don't understand all the questions, but it strikes me that where I am seeing good ideas, they come from people who do creative planning and utilization of assets, and maybe it isn't an insurance company that does it. An insurance company sort of always has that "In case everything falls through, you have got this by way of back-up."

But right now, they are not providing the leadership. But then neither are we. We are doing tax reform without any good sense of your problems. There is nobody asking that. People are saying, "Don't cap 401(k). Don't have IRA offsets." They are not saying, you know, "Corporate America wants to see, not just the 35 percent tax rate on corporation. We want to see you not taxing (inaudible)" or something like that. We are not getting any ideas.

Everybody is reacting, and nobody is giving us any ideas about if we are going to do tax reform, what we

ought to be doing.

VOICE: I think our point on the tax thing has been one that is coming at everybody rather quickly under the heading of reform, and I know there are a number of companies that I am associated with that are sort of taking the position, "Well, you know, we have got to (inaudible) and we have got to see where there is something in there that is good for us, and where there is something that is bad for us, and put a patch on the patch on the patch," and, you know, deal with it that way.

Then, you are right. There is very little sitting back in a constructive sense. I don't think many businesses feel that they would be very instrumental at this point in time, individually, with the House out, and we can't get -- people say, "Well, why doesn't the business get its act together?" Well, you know, I think basically business has been lacking.

We are individuals running individual businesses, and we are greedy, and we want to see whatever we can get out of it that is good for us, so even as prestigious a group as the Business Round Table representing all the large companies has a preponderance of view in favor of any of the tax issues on the one side versus the other, but not a unanimous group by any means.

When Packwood came out recently with his

modification of it, a number of those who were tracking right along behind jumped ship.

VOICE: -- fragment this thing even more. Everybody got out their --

(Laughter.)

VOICE: Take care of the oil, and take care of timber --

(Laughter.)

VOICE: -- and gave away the IDCs. Bob could be counted on to do that.

(Laughter.)

VOICE: Well, coming from Oregon, he better keep an eye on the timber, I suppose, which is a major part of our business.

VOICE: The point that -- on taxism, I maybe offer to help you, we have come to this rifling thing, and listening to this last weekend from a number of companies who are all members of the Business Round Table and listening to their chairman talk and speaking myself to the point, it almost seemed like the whole table was out of order, and everybody was saying, "There is only one thing to do. Grab all you can grab, and run and hide, and hope they don't find your little niche over here," and I thought, "Jesus, wait a minute." You know, this is a major issue that has to do with the next 20 years in the United States.

I came to the conclusion, rightly or wrongly -- I appreciate your view of it, but the whole issue of reform is now gone. The issue is becoming -- it seems to be moving to one of revenue raising without calling it that, and it has become so complex and so compartmentalized and so rifled that it will follow its own weight, and somebody will say we have got to start all over again. We have got to do something completely different.

Is that way out?

VOICE: No. The Treasury 1, even though everybody went and got their rifles in the beginning, they put them away after they found out that, you know, if everybody was going to get treated this way, maybe we weren't so bad off, you know.

But Treasury 1 was as close as you could get to flat rate taxes for major base broadening that affected everyone, not equally, but it affected everybody.

Since then we have disintegrated the notion of broad base tax reform by protecting special interests in the name of some national policy to preserve oil, gas, or timber, God knows what, and at that point, the only reform that was left was a three-tiered individual rate and a 35 percent corporate rate.

So that is the only reform that is left. The question now is, "Where do you get the money to pay for it?"

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And I have always believed you couldn't get it out of the base, not in one fell swoop; and we should be paying to get us out -- we should broaden the base, but we probably ought to collect the money someplace else, with a consumption tax or something to pay for that, but you wouldn't get that much to go from 50 to 35 or 46 to 35 out of base broadening on the current America which is really two Americas, at least.

I mean, there is half of this country that is going, going, going, but the other half is struggling with the reindustrialization of the country and all that sort of thing.

That is a challenge tomorrow. Starting our little debate is going to be, do we get the money for the rates out of the base, or are we going to argue that excise, removing the deductibility for state and local taxes, or removing the deductibility for excise taxes, is base broadening? I am going to say it is not base broadening because it is all inequitable. It is inequitable as between states. It is inequitable as between industries. It is inequitable as between businesses within an industry. It is inequitable as between country -- businesses that operate in rural areas, businesses that operate in cities. There are a lot of inequities when you move to eliminating taxes paid the base on.

Is that base broadening or is it not? And we

will lose sight of, you know, some important national differences in that way.

No, you are right, and it is too bad. I think it is all predictable. Reagan believes from his General Electric days that the lower the rate, the more the income. I don't know what we can do about that.

And we have to do base broadening, anyway. That is where you break out of it because we all know we should be doing base broadening. We all know we are going to get rid of the investment tax credit sooner or later. The other question is how you get it done.

VOICE: Are you impressed with the fact that has been tried twice before, the investment tax credit, and both times, related or unrelated, we have had a dip and had to reinstall it?

VOICE: Yes, I am impressed by that fact, for all the reasons that I stated in my opening remarks here about the fact that we are in a new era, and all that sort of thing, where we really are going to look carefully at where we put our subsidy money. We didn't do that in the '60s and '70s. We bought a tax because it related to cost in excess capital.

I don't think that is where we are headed now. I think we are in a free market.

VOICE: Another aspect to the new era is that we

are clued in the global competition. We feel that in a number of our businesses, and on some of the boards that I am on we feel it, most notably the automobile business feels it intensely, and we are dealing away major industries because we are not as subsidized, bad as that term may be from an industry point of view, we are not as subsidized as the competitors, and they view their business in a much more integrated part of the society, the Japanese being the classic case of, you know, see it as a means of producing hard dollars.

Why hard dollars? Well, that is the only way you can buy oil. They don't have any oil. They don't have many natural raw materials so they need the hard dollars to buy those things so they need an exporting automobile industry to develop the hard dollar so then the automobile industry becomes something that gets what it needs to compete in the world: a very material subsidy for exporting automobiles. And that is the real world.

Those are the guys who are trying to take our markets, and I think we deal at times with the issue of taxes and the issue of how we raise revenue and how we deal with our subsidies on a national basis when the arena really is a global basis. And all that does is then add two powers, I guess, to the degree of complexity of the problem.

But it is nonetheless there, and the extent to which we remove an investment tax credit or whatever other form the subsidy takes from industries that are struggling to survive in the global competition and not really doing very well, American industries today -- I think we ought to at least take the responsibility for the probable consequence of that.

Then I wonder, you know, can we exist without a viable, growing automobile industry? Can we exist without a viable, growing tax system?

VOICE: (Inaudible.)

VOICE: England does, and they don't have much of that. I hope we don't take the role of trying to emulate them because I think they are going down the tube, and would have been down the tube now had they not found offshore oil.

Those are the dilemmas I see. I guess, in a matter of principle, I would say that when we deal with -- I have no problem with dealing with a subsidy as a subsidy, giving it to the consumer and banking on their having the intelligence to use it effectively, and from our point of view that works well because we would like to (inaudible) the consumer dollar.

But in the broad sense, whether to do that within a context of domestic or global, I think deserves some thought.

VOICE: And I would argue that we do, but I know that I am swimming upstream in the near term. But that is where it gets back to having a national security policy strategy.

In other words, if you adopted my theory literally in this interdependent world, you would ask the American consumer what they want by the way of quality and what they are willing to pay for it. And they can get it from the Japanese or the Koreans or --

(End Tape 1, Side 1.)

VOICE: -- everybody that preceded me got to deal with the easy answers, and I am left to deal with the hard ones. Well, the easy answers in the '60s and '70s were to spend money on good ideas, and we found good ideas all over the country, but not necessarily in Washington, D.C.

(Inaudible), as he was kind enough to point out, there is always a place for people who have good ideas. I found it an easy to state to represent because people are always very anxious to tell you where to go or what to do.

(Laughter.)

VOICE: (Inaudible) that started out as American Rehabilitation, and now even the for profit policy making business (inaudible) for some reason or other.

But because we are what we are in this country, the de Toquevilles found us as a little bit different from -- at least from the French and perhaps from other people. We are great at associating. We are great at networking. Now we call it networking. We didn't do that in the 1830s, but the whole of the emphasis, of course, of this country is when you find a problem and a person with a solution, you have just got to spread it like peanut butter or something. You have got to keep moving it around.

What happened in this country in the post-World War II period was we got this engine of redevelopment or development going in America through the emphasis on

consumption, the emphasis on spending, and the emphasis on recycling product and so forth. We found we were using inflation and expectation and having without paying for it and all that sort of thing. In this country we were able to have a whale of a lot. We could have inventions. We could have innovation, and we could have new cures, and we could have remedies for everything that came along.

So in that atmosphere the place where new ideas actually came about was through problems at the local level, community level. They did not have the capacity to finance them on a community basis. Then so they would take them to the state level, and the state didn't have the capacity to finance them because states were largely rural dominated legislatures, part time legislatures, even in our progressive state like Minnesota. The legislature only met for 60 or 90 days once every two years.

So we didn't have the capacity to deal with public responses to new remedies for various problems.

So politicians took these solutions that were created in places like Minnesota to Washington, D.C., where inflation was taking people's income in the form of taxes; and the two met up in Washington, D.C., and a great idea would come out of Sister Kenny or American Rehab or something like that, and go trotting off to Hubert Humphrey's pot in Washington, D.C., where Hubert will search

out 51 percent of the Senate and 51 percent of the House who have similar problems in their own states.

And he had a solution. He converted it into a category for (inaudible) program, put enough money against it to at least get demonstrations out there, or (inaudible) out there, or for people to chew away on, and over a period of 15 or 20 years we developed something called cooperative or categorical Federalism, and we all knew the solution became national programs to solve problems.

Now, obviously, in doing that we did a lot of good. We found that we developed a lot of capacity in a lot of people. We solved a whole lot of problems, and we kept the frontiers of cure and remedy and so forth moving quite rapidly across this country.

But in the mid '70s we got to the point where people started complaining about the fact that all of this good that we were doing was starting to cost so much. Taxes were too high; the Federal Government and other governments seemed to be spending too much. The cost of health insurance was rising then at 10 percent a year. (Inaudible) were up 20 percent a year or 30 percent a year or something like that. People started, you know, getting a little tight with their money.

In California in 1976 or '77 we had Proposition 13. that was exceeded by Proposition 2 1/2 in Massachusetts

in 1976. We had a Governor from Georgia run for President of the United States on the platform that he would balance the Federal budget by getting rid of all the bureaucrats in Washington, by getting rid of the Washington that told everybody else how to do things.

So it was the flip side of what Hubert and everybody else was doing, taking all these ideas to Washington and bringing them back in the form of money and solution. He regarded it as too many bureaucrats out there, too much government, too much spending; it cost too much.

And so the country threw out Gerald Ford because he was one of those guys that took ideas to Washington, converted them into money and -- they threw him out, and they put Jimmy Carter in charge.

Why did they put Jimmy Carter out and put a 70 year old movie actor in charge? And if their objective was to start living within our means, balancing the budget, things like that, what is a prudent government (inaudible)? We went from a $400 billion deficit when Carter took office to an $800 billion deficit or national debt when Reagan took office, and now it is $221 trillion, headed for $3 trillion.

So how in the world are we going to deal with this appetite that Americans have, doing good for each other, within this sort of new-found American ethic which is, "I don't want to pay for anything that I didn't order,"

that kind of a notion.

Well, in health care we have an opportunity that we all have in some other areas to deal with that particular issue.

I am in my capacity as Chairman of the Senate Select Committee on Intelligence, I am bringing some of these same solutions to bear there. I have written a book, for example, called Neither Madmen Nor Messiahs which helps to bring me here to you today, and which is a policy of national security which, in effect, take the national security defense policy of this country, turns it on its head, and says, "Why do we do this? Why do we do that? How much of this do we need? How much of that?"

It sort of takes defense policy away from the Navy, Air Force, and Marines and puts it in the hands of the citizens of the country, and as an effect of consumer choice of national security approach, much as I have chosen to follow in the gulf policy and area as well.

The thesis of reform in health care is responsibility, and the one word reason why we are following consumer choice in the financing of health care, the word is responsibility.

It is illustrated as follows. I am just getting a glass of water.

In my last visit to Puerto Rico I had the

opportunity to visit the San Paolo Hospital in the suburbs of San Juan, and the very bright young administrator of that very nice hospital -- it looks like it is owned by the doctors -- was telling me about their problem with malpractice. To illustrate it he used the example of a 55-year-old woman who had just suddenly died, and they just settled her malpractice claim, but the background was that she came in with a severe cardiac problem into their intensive care unit, and they noticed while she was there that her husband would come in twice a day with a package of cigarettes so she took her head out of the oxygen tent and would puff away like this.

Well, he became dissatisfied with the care she was getting at the hospital so they took her to Houston Methodist for one of the two famous doctors over there. I think it was Bigey or maybe it was Cooley -- I don't want to blame either one of them -- operated on her, did a couple of bypasses, and she died.

So the husband sued both Methodist and San Paolo, and they both ended up settling.

But the point of it was the administrator asked me as a rhetorical question, which was, "Why do I have to pay for a self-inflicted injury? Why do we as a society have to pay for self-inflicted injuries?"

(Laughter.)

VOICE: So I guess I sat there with my pipe all the time. I finally gave it up, but I am not here to make a health point here.

The point, is self-inflicted his responsibility? And that is really the point of the whole issue of consumer choice in health care, behind prospective payments and vouchers and competitive medical plans and things like that. I want to lay that out very briefly, and then let you talk to me about why it doesn't reply or why if it were done differently, and so forth, in the rehabilitation area.

But I need to lay this framework for where we are headed so you can help us make appropriate policy. You can see that we are not up to regulate the health care financing industry. We are up to restore responsibility to you and me in the area of our health and the health of people around us.

How do we restore that responsibility? Simply by making people recognize the consequences and the cost of the consequences of their actions. If every time you went to buy your accident or health or life insurance or your whatever, your pension with your companies or whatever, you saw something other than age and sex as a factor in your premium, like lifestyle -- you might say, "Well, how about that? You know, lifestyle does make a difference; and you can put dollars next to it."

If that were the way you were raised, you would find some way to adjust your lifestyle to your affordability or your affordability to that lifestyle.

We, my generation, some of whom are in this room -- very few people here are as old as I am -- but my generation just never had that experience. My generation was born in the Depression of parents who swore that we would never have to live through a Depression.

So they deliberately created having without paying for it. They deliberately created this environment in which I never had to suffer the consequences of my action.

I was raised to believe that it is much easier to get sick than it is to stay healthy. I was raised to believe that if you wanted time off from work, go to the hospital, and if you went there, you know, people would send you flowers. Your employer would pay. They would send you flowers, cards, and come and visit you. If you stay at work, you have to work for your money. And people complained about what you did, but nobody ever said a nice word. Nobody ever sent you a card saying, "Thank you for staying well, or healthy, or whatever."

So if I am raised on that, then is it any wonder that I end up paying $500 or $600 a day for a hospital room and all that sort of thing? I mean, price is no object. I

have a right to get sick; and when I am sick, I have a right to the best care, whatever that means.

So where were the incentives in the provider system in my time to do things more efficiently? None, obviously. I don't know how the dentist ever got in the fluoride business or the "Brush your teeth every six months," or, you know -- working himself out of business. Dummies. You know, a lot of dentists are in trouble now because they, even though all the incentives worked the other way, they fought the tide, and they had to use legislatures to force fluoride on us. They had to use -- but they were able to get through to insurance companies and things like that, and a six month examination.

But only in dentistry did you clearly see in a whole profession, you know, you see this kind of emphasis, and actually see it work.

Everywhere else we have had to rely on major changes in the overall financing in order to provide the doctors and the medical professionals, the rehabilitation experts and the therapists, everybody else, with the axiom, "Do better for less." To get greater value for a smaller expenditure of time, money, and effort.

So we are moving in the direction of enabling you to become the supplier of the most needed product at the best price by prospectively pricing the sick care that we

provide.

How we get there, nobody knows exactly how we are going to get there. You know how we start. We start by taking Medicare which is the largest of the insurance programs in this country, covers 31 million people, something like that; and using Medicare as the engine, we changed the reimbursement system for hospitals. We started to change the reimbursement system for hospitals.

It was always our intention, as you know, to continue this prospective pricing until it included all providers. In the beginning I for one thought that you could take the hospital DRG and then just expand it. You could fold in SNIP and the rehab and, you know, all that sort of thing -- and the doctor and everybody else, fold it into one price; give the doctor the money, and let him decide whether the person went into the hospital or went to the rehab unit or stayed at home and got home help or whatever. Let the physician or some other sort of broker of health care decide where to use that money.

Now I am less confident, substantially less confident, let's say, that you can have one price for 467 or 468 or some other number of procedures. You may be able to do that for certain -- for hospital stays, but you probably need some other kind of -- you clearly need another prospective measure for physicians, and we are moving in the

direction of relative value scales which the physicians had recommended to us many years ago, but the Federal Trade Commission turned down (inaudible), offering it up as a sensible way to do it; which only proves again that had we put health care in this country in the hands of professionals a long time ago instead of putting it in the hands of those of us -- we all might have been much better off.

Well, with physicians we are going to a different kind of a prospective pricing program, based on relative value. In the other areas we are -- all I can say to you is that we are going to try to prospectively price our purchases, but how to do it -- it is a little difficult right now for us to determine.

Dr. Hess mentioned in the introduction that the future of sick care and health care purchase in America is a private health plan, now called competitive medical plans, in this legislation which he referred to and which I introduced on behalf of the Administration. It really is not my work of Medicare restructuring.

That is a whole other thing that I am working on, Medicare restructuring. This is the Administration's view, 1985, or whatever it is. They call it health benefit organizations, but however you look at it, the future is health plan which incorporates a wide variety of health

related services from wellness, prevention, and diagnostics through the acute care, the rehabilitation, whole health, and then eventually into -- for the elderly in particular and for the disabled, into a system of long term care which is primarily social services.

Though that kind of coverage will be bought from private health plans in the private marketplace and will be paid for in part by the Medicare trust fund at the premium level, in part by employers, and on the treatment level where employers want, have promised, or made commitments, they can buy -- and in part by the individuals involved, so that not everybody is buying the same plan. Everybody can buy as much as they want, and they might pay different amounts for different parts of this health plan.

It is also conceivable that we will see three different health plans on the market. You might find one for health promotion and disease prevention and acute care. You might find another one for social -- what we call the social HMO or the lap-over between the social services and the health care. You might find a third one for other, more refined forms of long term care which include shelter components and things like that.

I am not sure. Nobody is dictating how these markets work. We are just trying to encourage a market for private health plans to get us out of the business, and that

is sort of the bottom line of all of this, that having started off to use Medicare to show the value of prospective pricing, we don't want to stay in the prospective pricing business too long because we aren't sensitive to the marketplace.

In fact, 30 years ago when Hubert Humphrey and everybody else came down here to do good, they had to do good like peanut butter, as I said. You know, they found a problem, and they spread it through 50 states. They even spread it in states that didn't have that problem because that is the way they had to do it. And, of course, people found problems, even in the states that didn't have them so they could access to these programs, and that is where the wasted resources came.

So with this regulatory system we are currently employing, problems are not approached the same all over. They can be approached differently, and at different rates of cost, so it is inappropriate for us to stay in the DRG business for any longer than we have to so our objective is to move out of it and leave the financing of the sick care in this country to private health plans who will make their own arrangements in the marketplaces in which they operate for the payment of a variety of services.

Otherwise, we have run into, you know, sort of the unfair problems. We have run into the swing bed at the

hospital versus the nursing home problem. And we have run into the hospital based rehabilitation versus the free-standing rehabilitation. We have got all these problems that a regulatory approach does not handle very well. It really doesn't handle very well; and obviously we shouldn't be dictating the mode of service delivery.

The value that a consumer puts on the product, the value that a professional puts on the quality of care that is delivered in a certain area, those are the kinds of things that ought to dictate the setting.

Price can dictate the setting as well. That is part of value, but if we try to dictate the setting as we presently are, and insurance companies do -- you know, you can only get reimbursed if you get your rehabilitation here rather than there. We pay for it in the hospital; but we don't pay for it in some other setting. That is ridiculous. That is a ridiculous way for us to approach the delivery of care.

We used to do some of that because we were trying to force things out of hospitals. For example, in ambulatory surgery we set up one rate for ambulatory surgery centers just to force the business away from the hospitals and into the ambulatory surgery centers.

Well, that was just so we could find out whether the marketplace in ambulatory surgery worked, and we found

out that it did. Now we are pulling back to the one rate. Let the marketplace decide where you go for those services.

Well, I think probably for the sake of time, having given you that kind of a background, I should shut up.

In terms of predicting where we are going this year, it is impossible to do that with any accuracy. You know we are sitting on a freeze which is ridiculous. You know my position on that, which is the freeze will kill reform quicker than anything else. But I tell you that I got beat on the floor last year by Gramm-Rudman and Packwood and others who think that Medicare is simply a system of payments for doctors and hospitals and rehabilitation centers and so forth. They don't think about it in terms of health care for people. That becomes your responsibility to try to get that message across to a lot of the people in this Congress.

This year hopefully we will expand the dollars that are going into the system, both in the pass through, like the rehabilitation facilities and also to the hospitals. I don't know that we will be able to make it. Nobody knows for sure where we are headed in terms of making our $144 billion target.

I just know from experience that Medicare, because it has saved over $30 billion to the trust fund and

the taxpayers of this country, is now an easy mark for budget cuts. Because we have done good, because we have shown people how to change the system for the better, because we are demonstrating that people who care, care as much about efficiency and affordability as they care about the quality of the product, we are being penalized, all of us in policy reform.

It ain't fair, but -- and hopefully it won't last for long if people like you take strong positions in favor of reform and against using budget cutting against that kind of reform.

I think the good news, though, is that the news of change and reform and value and those sort of things is getting out. I think there are more people all the time that are coming to Washington, holding conferences here, and talking about the values of the changes that are taking place in health care so that I think that we move this year toward folding capital into hospitals, next year or this year doing physician reimbursement; that we will be able to do the changes that are needed in the reimbursement of health care.

But don't worry that any of us here are trying to tell you how to do your business. It is really up to you to tell us how best to finance the access of people into the kinds of businesses that you are in, keeping in mind what I

said about our objective: individual responsibility, individual responsibility, value for what you receive, and value of the combination of the quality of the care that you receive, setting in which you receive it, and the dollars that you have to pay for it.

And then the third, of course, is just the long range progress towards finding better ways always to do things. Nobody could ever perceive this reform as stopping America in its tracks. We have to keep finding better ways to do things all of the time, whether it is drugs or rehabilitation therapy or whatever it is. We can't put a crimp in the system that says just because it, quote, "costs too much," we can't afford to go out and find better ways to do things. We always have to keep in mind that it costs money to make money, and that we need the ability to make investments in future care, new kinds of care. We can't ever stop the system in its tracks and say, "I'm sorry; all we can afford is what we are doing today." Baloney.

We do so much inefficiently with the health care dollar in this country. There is more than enough for creativity and innovation and ingenuity and better care in America.

So thank you for inviting me to be part of this. I will be pleased to respond, to the extent that I am able, to respond to anybody who has a question? Who wants to be

the first?

VOICE: Senator, if we see the -- moving to a voucher system or more choice by consumer for health care, for purchase of health care, are we going to see the disappearance of PROs? In other words, if we are going to make a consumer choice purely, will the industry drive for quality reviews of services to patients?

VOICE: The question, as I understand it, relates to the future of peer review in all of what we are doing.

Let me say as the champion of peer review here that I think that the -- peer review we will always have with us in a professional sense. I expect we will not have it with us in a legislative sense.

Peer review has been terribly important -- thank you -- to work this change so that we have medical professionals guiding the change from the cost-based reimbursement system to the prospective reimbursement.

When you have pre-admission screening, when you have all the rest of these new things happen, you had better have some medical professionals around to make sure it is done sensitively.

Now, I realize in some parts of the country it is done better than in others, but that is the theory of peer review now -- utilization -- help us with utilization. Help us with pre-admission screening. Help us with quality.

Help us with physician practice pattern changes, and clearly that has happened, and the over-utilization of resources is coming to an end.

But all of that means we, in the larger sense, need to have the helping hand of peer review in that process. But once that process has been accomplished and a lot of these new systems are in place, then I think the nature of peer review changes, and it gets back to where it has always been. It has been sort of an institutional peer review. It is a built-in quality mechanism in each institution that says, "Hey, if we don't keep quality up here, number one, we aren't going to get the business," or whatever.

That is impossible. We have always done this. Medical clinics always do this. Any group of medical professionals always has a way to maintain the standards of quality care. So I suspect that is where we will end up.

In addition to that, of course, you have at the state level, you will always have licensing and procedures like that. Does that address your question?

The next question?

VOICE: It seems to me if you want to make an impact on health care, on the Medicare trust fund, that you would consider long range a means test for Medicare, return insurance coverage back to the insurance industry. Have you

seen any movement on the --

VOICE: Well, where are you from?

VOICE: From California.

VOICE: Okay, you have got two Senators. Get them to endorse my bill. I can't think of the name of it, but --

(Laughter.)

VOICE: -- I put in a bill that means tests Medicare in 1982, and I -- it is still around. I have got those scars -- and I will tell you how I did it.

I combined Part A and B, put a premium on the combination of that, charged about 15 percent of program costs to everybody so that the poor could not say they couldn't afford Medicare.

Then I got back the difference between 15 percent of program costs and 95 percent of program costs off of one percent of the adjusted gross income on everybody, on all the elderly who --

(End Tape 1, Side 2.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape
Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

Speech to

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VOICE: -- we have a distinguished subcommittee under the leadership of my successor, Bill Woodside, American Can, who are studying this multi-faceted and very complicated issue.

So I'm very pleased today to have the opportunity to introduce to my colleagues and to our distinguished guests Senator Dave Durenberger of Minnesota. As you probably know, he is Chairman of the Senate Subcommittee on Health. There are probably a few, if any, Members of the Senate who exceed his reputation for leadership and thoughtfulness and substance and he brings daily to the many tough issues that he and his colleagues must confront a decisive judgment and a great dedication.

I should point out that our Committee, our CD Committee received a bit of a well-time push by our distinguished speaker at the time of our Congressional Breakfast on the deficit paper. The Senator asked us to accelerate our deliberations in this area and of course he is absolutely right. The study has really taken off. So, the Senator has done a little lobbying on us and a little stimulation and it's really deeply appreciated.

So without further ado or comment, I would like to turn the mike over to Senator Dave Durenberger.

Senator?

SENATOR DURENBERGER: Thank you.

(Applause.)

Well, I'm from the government and I'm just here to help.

(Laughter.)

If you believe that, you'll love me in the morning, too.

I'm going to try real hard to be brief because I have the sense that my beeper is going to go off any second, and yet, there is so much that I would like to say to this distinguished group. I am tempted not to say anything until Graham Plater gets here.

Isn't he on the list that's supposed to be here?

VOICE: Yes.

SENATOR DURENBERGER: And we'd like to make him -- make you all mad because I don't get started because he didn't show up. After going down on the Floor and debating for a National Rail Passenger System last week, I am more than a little upset that he didn't bother to show up and listen to me talk about it.

(Laughter.)

Because, in part, that is what I'm going to talk about today, and I'm going to put it in a context that I trust is a piece of reality as perceived by one participant

and then just some expectations on the part of somebody who likes to think we can do things more quickly than it turns out we can do them.

A couple of months ago I needed a joke for a trip to Texas and I wanted it to be short Texas joke, which is an oxymoron --

(Laughter.)

-- as many of you know. So somebody said ask them why there were so many heroes at the Alamo, and I said, well, what's the answer. And they said, because there was no back door.

(Laughter.)

And they even laughed in Texas, because in Texas they knew that all the folks in the Alamo were from Tennessee.

(Laughter.)

But I got to thinking about it in the context of the rest of my speech, which was about deficits and spending and all that sort of think, and I said to myself, you know, the Congress is very much like the -- the Congressman in the present, very much like those Davy Crockett and the boys that were caught in the Alamo, and we've been caught there for the last 15-20 years. Maybe not that long. Certainly since Jimmy Carter was elected President.

Well, there's 536 of us in the Alamo, surrounded

by 230 angry people shouting Proposition 13, Proposition 2.5, cut the budget, you know cut off their water, government spending is the Washington Monument. You've heard the line recently, haven't you? But that's what they have been screaming at everybody in politics for a long time.

Now, the reality is if you look at us in terms of being in the Alamo, the -- you know the reality is there is a back door to the Alamo, and whether you refer to your Member's newsletter -- and I invite you to go home and if you can find it in the wastebasket or wherever you put these things -- to look for the last newsletter that your Member of Congress or your Senator wrote to you. And more on the House side than the Senator side because we can't use "I" more than five times, or the first person more than five times in our newsletters.

But in most of them you will find us attributing the ills of government and the failure to find a front door to the Alamo to the Congress of the United States. Every even-numbered year we come out on your television set and we tell you that we have plans to balance the budget. We have plans to make government the master -- or the servant of the people, rather than the master of the people. We have plans to strengthen national security -- as I proved in my book, Neither Madmen Nor Messiahs -- without costing anybody any

money.

Everyone of us has done this for the last 15-20 years. As a result, we have the institution incapable of addressing the problem because each of us has appealed to enough special interests to make 51 percent in our districts, and we have done that, and all of us are the same. The Democrats are the same as the Republicans and everybody does it. And the special interests have not emasculated the politicians in the country. Quite the reserve. It's the politicians who have created a special -- set of special interests in this country that have appeared to do the reverse.

So, we have no ready instrument with which to address deficits, tax reform and a lot of the other problems that face the country , until last November. Last November the Republican Party won; the Democratic Party lost. Even Tip O'Neill admitted it. All of the Democrats started giving advice to each other about how to reform their party. Fortunately, only Republicans are listening, so we're still ahead.

But, in addition to making speeches, Tip O'Neill went and stood in the back door of the Alamo and he said to us, you ain't getting out. I've had enough of this. I know how to balance the budget. I know how to improve the quality of government. I know how to do all that. So, you

aren't getting out in 1986 until you do something.

So, we turned to our leader. He had won every state in this country, except for 3,170 benighted souls in might State, Ronald Reagan had, and we said, Mr. Leader, show us how to find the front door to the Alamo. And he said, it's simple. If the problem is balancing the budget, I'll tell you how to do it. And we said, how, HOW? And he said, a constitutional amendment. And we laughed. Those of you who watched the State of the Union know we laughed, literally laughed during the State of the Union message.

So, we got together and we said amendments don't balance budgets, people do. And he said, oh, okay. Here is a -- here is my version of the budget for the next three years, and it had at the end of it a $144 billion deficit for Fiscal 1988 and we said, Mr. President, that's not going to get us out the front door of the Alamo. And he said, I'm sorry, you know. He didn't say, I believe in debt and deficit, even though he had doubled the national debt and tripled the debt service in four years. He didn't acknowledge a belief for the deficit. He still picks on the deficit. But he delivered to us a three-year declined in the deficit to $144 billion under the most optimistic projections to $144 billion.

We said that wasn't enough. We went to Blair House as Republicans. We started a process which ended at

3:08 a.m. last Friday morning. During the course of that process we didn't do everything everybody would like us to do. We probably did a lot more than a lot of people wanted us to do. But it was an interesting process.

And the reason I mentioned Graham Plater is simply because in a little half hour debate over Amtrak we touched on the tip of the iceberg of the future public policy debate in this country. And it's best summarized by Gary Hart's advice to the Democratic Party two weeks ago when he said to his colleagues, it's time to debate not old programs but old values. And there is a great fear on my part that in the next three years Republicans will spend a lot of time beating up on old programs, while Democrats are finding new ways to beat the demands of old values.

In the Amtrak debate, Bill Armstrong defended eliminating Amtrak on the same theory the President used: $35 per passenger is too much. Bill said, the users ought to pay and if the users don't pay, then get rid of it. Joe Biden jumped because there's a lot of Amtrak trains going through Delaware and because he's a good speaker and because he has some sense of national purpose, Joe jumped up and said, hey, how about the ranchers in Colorado. Can we have all the ranchers in Colorado pay for their own water? And Bill said, Blrrrrr -- like this -- and he said, I guess so.

Now, he could say I guess so, yes sir, because we

weren't voting on giving water, free water, to the ranchers in Colorado at the expense of people in Delaware or Minnesota. We got a freebie on that one. But it touched on something we are not touching on today and that is a sense of national purpose. A sense of national purpose.

I have come -- I have not come here today to give you a speech on national purpose. I came to share with you my view of addressing the crowds outside the Alamo with some reality and then to touch on the differences between your approach to education and your approach to health care as I see them outlined here today.

There are five ways that we get people to spend money for public good in this country. Five traditional ways. There's probably more. I see economists in this room so I should be careful. But I only know of five ways. One is direct spending. I spend $600 per Lockheed toilet seat or for light bulb, or I spend $74 billion a year on Medicare and I spend $14 billion a year to build highways and that sort of thing. $949 billion this year in direct spending. That's one way. You all understand that one.

We do collect money from a general tax base and apply it to specific purposes.

The second way is illustrated by an add that ran in the Wall Street Journal in December right behind the Wall Street Journal's first editorial condemning government

spending. Government Spending, I. I thought it was clever they used Roman numerals. That's to indicate how archaic government spending is. But on the back side it has a quarter page add from Cessna,a nd Cessna says, to me, it says there are two ways to buy -- or two reasons to buy a Cessna single engine aircraft. One I can remember; the second one I can't because the first one touched me.

The first one said because -- this is exactly the words -- because the IRS will give you all your money back. Now I read on, and I'm on the Finance Committee. I knew the answer before I read it, but there it was. The investment tax credit, ASRC, the interest deduction. You know, you name it and you can get a free -- and I went out and priced them. $44,000 is the cheapest one; $213,000 the most expensive single engine. We all ought to have one, right, in our back yards or someplace. You can get it for free from the government.

So I went out and bought myself a second-hand Olds Cutless Cierra because I needed a second car and I wanted to buy American. I didn't really want to, but I did.

(Laughter.)

It's already in the shop.

(Laughter.)

I've only had it two months. So I went out and bought it. It cost me $9,200, with sales tax in Minnesota.

I went to my banker and I said borrow me $10,000. That's the way we talk in Minnesota. Borrow me $10,000.

(Laughter.)

So, he said how long -- you know, how long do you want to pay? And I said I want to pay nothing but interest. So he gave me, like he's given all of us, this little set of checks drawn on the U.S. Treasury and he said every April 15 you write me out a check drawn on the Treasury and send it in to me and you will have a car within -- I think it was five years to have me a car. Okay, that's tax spending. That's the one you're going to debate the rest of the afternoon, after you get through booing me.

There's a third kind. That's regulation. On the average American car it's $1,894. That's the way to get clean air, clean water, prevent emissions of pollutants into our air and our water. It's the way to get work place safety. It's the way to do a lot of equal employment opportunity. A lot of those things. I'm told it's $1,894 per automobile.

There's a fourth way, and I'll stick with automobiles as long as I'm on this role. You have a fourth one -- and it comes up again in health care -- is called keep the competition out. We have added $600 plus dollars -- that's a conservative estimate -- to the price of every U.S. automobile and $1,364 to the price of every Japanese

automobile over the last four years in order to keep quality automobiles off the market in American so that we can buy what is produced in American to save 26,000 auto worker jobs.

It costs us $15.7 billion to do that. It doesn't appear anywhere on the price tags on the automobiles, but you know it's there. It saved 26,000 auto worker jobs at $21 an hour. We did not have to do target jobs credits for them. We didn't have to do any direct spending for them. We didn't have to do any tax spending for them. All we had to do was send an invisible bill to every American who buys and automobile at the rate of either $600 per American car or $1,300 for a Japanese car and now we've saved those jobs and we've made maybe some people in this room rich.

Now, that is the view of that sort of keep the competition out. My pork producers in Minnesota want me to do the same thing because Canadian pork is 36 cents on the dollar cheaper and they want to keep the Canadian pork off the market and charge you more for your bacon and your ham and your sausage to do that.

In hospitals we do it best in New York, Maryland, Massachusetts and New Jersey. We say we don't want any competition in the hospital business. Keep the hospitals we got with all their inefficiencies, with all the poor, with all of the teaching that's going on here without putting a

price on it and we'll just have the government raise the prices 12 percent a year. We won't rock any boats, no competition, no nothing.

So that's the fourth way.

The fifth way is the one that my parents gave me, the result of which I have to pass on to my kids. That is my parents who lived through the Depression, found themselves wiped out and, like many people did, never wanted that to happen to me. So they created in the post-World War II period the notion that I could have -- my generation could have without paying for it.

I could have, and I did, a three or four bedroom home in the suburbs with a nice recreation room, two fire places, et cetera, with $500 down and forever to pay. And when in the early Fifties, mid-Fifties, late-Fifties, early Sixties, whenever it happened, the word finally got out that you could have a home in the suburbs with three bedrooms, no undesirable neighbors, for only $500 every body wanted it. They all got out their $500 bills and they stood up across American and said we want.

And we discovered we had twice as many people with $500 bills in their hands that wanted houses than we had houses. So what did we do? We raised the price of carpenters, we raised the price of steel and wood and all that sort of thing, and we raised the value of everybody who

already had a house, didn't we? So, if I had an $8,500 house I could turn it in for $20,000. Put $11,500 in my pocket. Take another $500 down and buy another one, and I did that. I did -- I don't want to tell you the story of my home. I'd rather have you tell me the story of your home over the last 15 years. We all did it.

We did the same thing with our cars with the interest deduction. We did it in a variety of ways. We used inflation in effect to build $23-an-hour labor into American Steel. We used it to build $21-an-hour labor into the automobile industry. And we did it -- I don't want to go through all the rest of it, but I think you understand the five ways. I hope you do.

You don't have to agree with anything I've said, and I'm not condemning any one of these five ways of doing it. I think the fact that we put telephones in every home in America by taking the long distances charges -- or the money in long distance and putting it into the farmers was fine. It was a great way to get the telephones out there. I think we did that in a lot of other areas of economic regulation. I'm not knocking anyone of these five approaches. I'm just saying we ought to understand that those are the ways in American that we have asked people to utilize their resources to provide for some other needs that this society faced. And I think only when we get to that

point are we going to understand something about the role of spending, direct spending, tax policy, inflation, regulation.

Oh, welcome. I've already talked about Amtrak. Sit down.

(Laughter.)

You're late for that part. Somebody will have to tell you at the coffee break what I said.

(Laughter.)

Now, I'd love to talk about tax reform. I don't think we'll do much in the way of tax reform because all anybody wants to do is reform the income tax. Nobody wants to reform the national tax system. Nobody wants to recognize the reality that you can't run this country without a broader-based system of taxation. That one of these days we have to tax consumption in America. One of these days. And let the people that import pay part of the cost of social insurance and some of the other things we do in this country. But I suspect all we're going to do is reform the income tax and if we do that you will end up with a minimum tax and with maybe even some kind of a surcharge and the other kind of popular Mickey Mouse approaches.

In the meantime, in the health care area we're making terrific progress on advancing the cause of the market place, competition, consumer choice and all those

sort of things, and we're doing it by recognizing that market incentives make a difference.

I looked at your educational strategy and I see that your strategy for change is a bottom up strategy. That us the individual school as the place for meaningful improvement, and I stopped right there because the part about the bottom up strategy, I thought that's terrific. You know, start at the consumer level. But then you didn't start at the consumer level. You went right to the school. And all the rest of it seems to focus, your recommendations, on the school. How are we going to run the school better. And there isn't very much in there about consumers, other than what you're going to do for them. We place special stress on the selection, training, motivation and compensation of nature classroom teachers.

Well, you didn't do that when you went to your health policy. When you went to your health policies you said how are we going to change the financing system. How are we going to make the consumers of health care more responsible. There is nothing in the health part that talks about stressing the selection, training, motivation and compensation of doctors or nurses or anesthesiologists or anything like that because that one was in the private sector and it was sort of being emasculated by the free lunch and health care program.

I think you've accepted the notion that the market place does work in health care if the financing incentives were just made to work better. The consumer came armed with the ability to buy and not to buy you, if you're too expensive, but to buy somebody else. You accept the notion that financing through the consumer is the way to go. But in education you're still stuck on the notion that we got public schools over here and private schools over there and we need to strengthen the public school by strengthening teachers and so forth.

What you really ought to do, I think, is put the professionals in charge of the system, just like we're trying to do in health care. Let the hospital administrators run those hospitals and let the doctors run those medical practices with the right kinds of incentives for keeping me healthy and, if I get healthy, treating that illness in a less expensive way.

That isn't necessarily the way the education part reads. But I think -- and I don't say that to criticize, only to compare. I understand the business community has a major responsibility for the future of education in America and I would just suggest to you that as part of your focus you do focus on what has worked in the health care area, consumer choice.

When you and I, as a part of business, took all

of the incentives for efficient health care delivery in America away from the system we made a big mistake. When we went to first dollar coverage, when we went to the notion that all you had to do -- with all due respect to the insurance companies in the room. You didn't do it. We did it. The employers did it. When all you did was say come to work for me. Here is your health plan. All the fine print. All you were doing is writing a blank check for everybody in America. That every time they had an ache and pain, go see a doctor. And there were no incentives for hospitals, no incentives for doctors, and no incentives for me to quit smoking, not drink myself to death, not wear safety restraints.

That's what we all did to America over the last 30 years, and I'm not knocking the buying in the place of employment. We still need to do that. That's still the best place to make the arrangements to purchase health care. But if we maintain a system that in effect says to the employees this is a gift from on high, the employee is going to say thank you for the gift. I can continue to smoke. I can continue to drink. Somebody else is going to pick up the tab for it. I will wear my -- drive my motorcycle without a helmet. I will continue to do these things.

And all of that, ladies and gentlemen, has given us more than a billion dollars a day in acute care.

I was in Detroit -- and I'm going to stop.

I was in Detroit last week to speak to the Economic Club, and before that I met with all the hospital administrators in Detroit. And they told me that in Detroit last year, southeast Michigan, the hospitals had $86 million in bad debt. They had $22 million in free care and they had $12 million in Hill burden obligations. And the administrator of the children's hospital said, Senator, do you know what the leading cause of death for children in America was last year? I said, no, what was it. He said, poverty.

So, in Detroit, where the auto workers get a $3,300 gift from you, the taxpayers, in the form of something they dare to call health insurance paid for by you, Detroit's share of 10,000 will die from inadequate health care because we can't afford to help educate the poor, black, first-time pregnant mother to the dangers of smoking and drinking and a lot of other things. We wait until she delivers a 750 gram child. We rush it to a $4,000-a-day incubator and hope that it stays alive.

And we wonder why we don't have the resources in America. Why our old folks are writing living wills. Why doctors are saying we have to have quality of life criteria for admission into this country. It's because we waste so many resources in the health area.

The answer is consumer choice. I ought to have something to say about some rewards for not smoking, drinking or whatnot. Lifestyle ought to be a factor. Choice of health plans ought to be a factor. And through that combination you're going to get competition and all that sort of thing working in the same market place that all of you have made your livings off of for so long. And if you can do it in the hospital doctor business, you can do it in education and you can do it in lots of other places.

Thank you very much.

(Applause.)

VOICE: Senator do you have the time and do you want to make the mistake of taking questions?

SENATOR DURENBERGER: Yeah, I'd be glad to.

(Laughter.)

We are -- at 2:45 the Intelligence Committee, of which I am the Chair, and I don't imagine that you knew the Senate had an Intelligence Committee --

(Laughter.)

-- is meeting to discuss Lebanon. Yeah, we can take a few minutes here.

VOICE: You guys are never this quite.

VOICE: (Inaudible.)

SENATOR DURENBERGER: Well, there are models of consumer choice in health care, for example, building all

over the country, particularly consumer choice of health plans and the health plans help to develop, as many employers do, the wellness programs and some of those kinds of incentives.

The only reason I'm interested in the subject is I come from a community that started experimenting with all of this sort of stuff in the business community 12-13 years ago and we started with the fact that if every employer gave employees more than one choice of health plan there would be more health plans in the community and with those health plans in the community you'd get some leveraging on doctors and hospitals.

In the education area, again, Minnesota is one of the leader. This year we are trying to pass a piece of legislation -- I don't think passed -- that gave juniors and seniors in high schools the opportunity to go to any high school they want to. In effect, a kind of a voucher system where they could choose to get out, and of course everybody reacted to it by saying, well, all the good hockey players are going to go the team that won the hockey tournament last year and all the good basketball players are going to leave to go somewhere else.

But the reality is that choice in education is going to start probably in Minnesota, the way a lot of other things -- a lot of other things do.

The Detroit situation -- the reason I gave you those figures is that it illustrates the subsidy problem. It illustrates the problem of the taking of the money from the long distance calls to subsidize the rural situation. We have subsidized the poor and we've subsidized teaching and we've subsidized high technology off the patient that goes into the hospital.

But we're not going to do that any more, and more some period of time the poor are in trouble. I mean, serious trouble. Unless we step up to bat to finance the indigent specifically in America in some way, they're in trouble because you can't continue -- you can't go to competition, you can't go to choice, you can't have this sort of thing working in your community and still subsidize the -- to have large subsidies, like the indigent and the teaching hospitals. Because if you keep the subsidies there, those hospitals that are stuck with the large indigent population or the teaching population are not going to get the business. All the business is going to go to the suburbs and to the for-profits and so forth. We have to deal with those subsidies.

Yes, sir.

VOICE: It seems to me we have a bit of dilemma, though, with these five options that you've laid out for us. Let's take a look at them for a second.

On the budget the Senate, of course, voted to not increase anything this year, so we --

SENATOR DURENBERGER: Oh, the fifth year running I think we've done that. That's major consistency.

(Laughter.)

VOICE: (Inaudible.) And we have taxes and everybody is talking about taking taxes out of the policy arena, so to speak, so we don't have that option. We can assume --

SENATOR DURENBERGER: We still have it, but it looks like it's difficult.

VOICE: (Inaudible.) Then you have (inaudible.)

And that leaves us perhaps with regulation. That doesn't leave us much in the way of government options to deal with the kinds of problems that you seem to be (inaudible).

SENATOR DURENBERGER: No, I think in the near term you're absolutely right.

We can do two things. We can -- if we build some kind of tax reform on the kind of budget restraint that we just got done, at least we do something for public confidence in the Alamo, and we did something for public confidence maybe we'd bring down the -- I mean, maybe we'd improve the bond market and, you know, do something to get the President to stop praising the strong dollar and so

forth and so maybe we would help out kind of temporarily there, even if we didn't do everything we needed to do by way of deficit reduction.

We have taken care of the inflation part, I think. There is a continuing sense of realism, although it's uneven, about the cost of labor in America. The cost of capital seems to be, by most people's consensus, directly relative to the size of the deficit and/or the confidence that people have in our ability to deal with the deficit.

Now, there are two other problems that I feel -- one is that we are opting for an on-going debt as a percentage of GNP, or debt services as a percentage of GNP. That bothers me a great deal, that we should run this thing up to $3 trillion by the end of the decade and assume that we can live a $3 trillion debt and/or a 2 percent of GNP debt service.

I'm bothered by that. I don't know why, but I'm -- I've just got to say I'm bothered by that.

I'm also bothered by the notion that there are enough people around here that believe the deficit should be used to eliminate most of the federal government. They don't want Amtraks. They don't want job core. They don't want -- I'm not going to praise you for having the job core in your education thing and you're not saying it for everybody. You've got a very specific purpose for it, but

at least the President won't recognize that, and you do.

So, there are a lot of people that think we ought to go back to national defense and they don't want us to get into the currency post roads, pirates and things like that.

VOICE: Well, if I can just follow up.

I was just (inaudible) sixth category that you haven't talked about and that is volunteerism. That's another way we can get the same things happening in this country when some of the other options that you've talked about get closed off (inaudible).

SENATOR DURENBERGER: Very good. Thank you.

VOICE: I guess you convinced them.

(Laughter.)

SENATOR DURENBERGER: Thank you all very much. I hope to hear from all of you again. I appreciate that.

(Laughter.)

(Applause.)

VOICE: Thank you, Senator, very much.

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Provided to the
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by Senator David Durenberger

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VOICE: -- from Minnesota, and I thought before I gave an introduction, which is not going to be very long, I might suggest we go around the room so -- give our names and companies so he knows who we are.

MR. SKIDMORE: Jim Skidmore, MCI.

MR. O'CONNELL: Jim O'Connell, Control Data.

MR. BROWNLEN: Lee Brownlen, Honeywell.

MR. McGANN: Hal McGann, AT&T.

MR. HOWELL: Bill Howell, IBM.

MR. MAXWELL: Bill Maxwell, (inaudible).

MS. CLINT: Lynn Clint (inaudible).

MR. ROWEN: Jim Rowen, with the Senator.

MR. HOLBINE: Bruce Holbine, Digital Equipment.

MR. O'KEEFE: Tom O'Keefe, Honeywell.

VOICE: (Inaudible), Sperry.

VOICE: (Inaudible), Sperry.

VOICE: (Inaudible), Honeywell.

MR. HUTTON: Dewey Hutton, Eastman Kodak.

VOICE: (Inaudible.)

MR. KLEIN: Ken Klein, with Xerox.

MR. SHUSH: Bob Shush, with Xerox.

VOICE: (Inaudible.)

VOICE: Senator Durenberger probably doesn't need much introduction to you, but you have to have an introduction so I'll give one anyway.

He was elected to the Senate in 1978 for a four year term to fill out Hubert Humphrey's term. He was re-elected in 1982 by a reasonable margin and we would all -- those of us who were on the staff at the time thought it was a tremendous margin since his opponent spent close to $8 million and that's a lot of money in the Minnesota election campaign.

He is presently serving on the Committee on Finance. He is Chairman of the Health Subcommittee. He is on the Committee on Government Affairs, Environment and Public Works, the Committee on Intelligence and he is the Chairman of that and -- that's the Select Committee on Intelligence, and the Select Committee on Ethics. I'm not sure --

SENATOR DURENBERGER: I'm not on Ethics any more.

VOICE: Oh, you're not Ethics. Okay. I was going to say you must have gotten a lot of waivers from the new Rules.

Recently he was the author of a book of Madmen and Messiahs, so if you want to know about defense policy I'm sure they have some copies over there or -- are they in all the book stores? Has it hit the book stores?

SENATOR DURENBERGER: Yeah. I don't know which ones, though. I have a little trouble finding it myself.

(Laughter.)

VOICE: It's on my book shelf.

He is a sponsor of the R&D tax credit legislation, of which we are very pleased since that's a -- seems to be a priority.

And I will turn it over to him to tell you everything he wants to tell you about tax and trade and et cetera.

SENATOR DURENBERGER: Thank you.

I found that nobody believes that the Senate had either an Intelligence or an Ethics Committee.

(Laughter.)

So I got off of one of them.

(Laughter.)

So I could make money, speaking for my publisher. Piranha Press, is really the name of my publisher. I know a lot of you have read the book. Those of you who are in the defense business in particular have read it cover to cover and found out which of your systems I disowned in the book. And some people took it very seriously. Last fall when the book first came out they thought it might catch on. I know some of the books, the people that make the david that shoots down outhouses instead of helicopters, they got very

very upset.

(Laughter.)

I forget which company that was, which one of you guys (Inaudible.)

(Laughter.)

Well, so much for the book.

Last night, or yesterday afternoon Jay Rockefeller put his long arm around me and said, hey, I talked to my sister the other night and I told her that one of the greatest, most brilliant, intelligent, thoughtful, fully, et cetera, people in the United States Senate was Dave Durenberger. I said, I appreciate that a lot. Did that discourage her husband from running again in 1988? He said, I really don't know. I didn't talk to her husband.

(Laughter.)

It was Mark Dayton, who is married to Elida, and Jay and I hope, now that they moved Chuck Percy out, that that's all of the incest we will have for a while in the United States Senate.

(Laughter.)

Well, I was asked to talk about whatever came to mind, and instead, I'm going to talk on tax reform and the budget and stuff like that, which is probably on your mind. There's a nasty rumor going around right now our caucus that you can't get lobbyists to help on the budget deficit

because they're all getting themselves ready for tax reform and that literally is what we talked about yesterday at our Chairmen's meeting on the Republican side, that we could -- having done what we think is a pretty good job in the last three or four months putting a spending reducer together and having watched Bob just dance that very carefully through the other Bob there in the last six, eight -- were any of you sitting up there during that thing? It was really a unique piece of drama.

But having put all that effort into it and having come up with something that make some sense, we really have a lot of stake even to the point of saying, hey, President, hold off on your tax reform proposal until we can get some action out of the House.

But the remarks were made that we'd seem to have trouble getting people like you all to keep pressing on the House side on the budget deficit because you're too busy lining us up for tax reforms, and that's just for the good of the -- that's not a critical statement in any way because I don't really care what you do. I'm sure you're for both, as long as it doesn't affect you in some way.

(Laughter.)

The thesis of what I would like to say is what I've been saying since the start of the year and that is that this is the year that -- I usually start it out by

telling my very little -- very short Texas joke. That's an oxymoron, short Texas joke.

(Laughter.)

The riddle -- it's a riddle. It says, why were there so many heros at the Alamo, and the answer is, because there was no back door.

(Laughter.)

Even in Texas they laugh at that because all the guys in the Alamo apparently were from Tennessee.

(Laughter.)

Having gotten away with that once, I got to thinking about the Congress as being in the last ten years of so, you know, Washington being like all the guys in the Alamo. There's 536 people in the Alamo and they're surrounded by 230 million people saying, hey, stop, stop. Balance the budget. Cut taxes. Cut spending. All that sort of thing, and they've been beating up on us for a long time.

Finally -- but the reality is that the Alamo we're in has got a back door and every even-numbered year we come out the back door one at a time. We present ourselves to you as having all the answers -- at least 51 percent of the answers, or the answers reflecting 51 percent of the concerns in our districts -- and we say if it weren't for the Congress we could do you a great job.

I can balance the budget. I can, you know, cure all the ills. The problem is the Congress, and we have been doing that for -- long before I ever got there. Coming out, appealing to the special interests -- creating special interests. Special interest organizations like this don't create selfish Senators. Selfish Senators create the aura of special interest and PAC influence and lobby influence and all that sort of thing.

And so we have done this to the institution. You haven't done anything to us. You don't have to be guilty at all about being a special interest because we have done this in our newsletter, in our commercials. Everything has been a blatant appeal to the individual or the special interest of 51 percent of our electorate.

So we find ourselves without an institution. When it really comes to having to deal with tough problems, we don't have an institutional solution. We don't have a way to get 51 votes because 22 people are up for re-election. We've spent so much time knocking the institution, we can't do it.

Fortunately for everybody, we won the election so big in 1984 with Reagan that Tip O'Neill finally decided he'd go stand in the back door of the Alamo, and he said, you guys aren't getting out. My party lost; you won, but you ain't getting out the back door with any more of those

excuses about you know how to balance the budget. So we all turned to our leader, Ronald Reagan, and said, Ronald, Tip's in the back door. He won't let us out. And Ronald said, well, don't worry. I'll find you the front door. And we said, what's the front door. He said, well, if the problem is balancing the budget, I got the answer. We said, what is it? He said, a constitutional amendment.

And if any of you were around for the State of the Union, remember when he said that we laughed our ass off. Right on the floor of the House everybody laughed. So the next things was -- if he said, all right, if that doesn't do it, I'll acknowledge that amendments don't balance the budget. People have to balance the budget. So here's how you balance the budget. So he gave us a budget that had a deficit in fiscal 1988 of $145 billion. We said, that ain't going to get us out the front door of the Alamo either.

So in effect we then went to work on our side to get it cut down to something smaller than that. But even at that, all that does is say we have courage, we have the will, you know, we apparently have the ability to put 50 votes together without destroying the country or treading too far on anybody's philosophy.

But that is only one part of the problem of overspending in America. I'm quickly going to tell you

about the other four and then shut up and respond to whatever questions you may have, because I have to go off and do this again to the Committee for Economic Development, which is interested in my views on taxing fringe benefits and things like that.

Besides the direct spending that we just tackled last week, the $600 toilet seats and all that sort of thing, we do four other kinds of spending in this country. The next one we will come up on in this process here is tax spending. I usually use the example -- either I can use my own example of that or I can use the examples around this room. You mentioned the R&D tax credit already. Do a certain amount of research and development and you get to use other people's money to do your R&D. If you're not in the business that needs R&D you don't get that kind of a break.

But more blatant, I suppose, is the fact that I can -- I went out two months ago and bought myself a second-hand Olds and called my banker and said, you know, loan me $10,000 and he did. So I know have a set of checks on the U.S. Treasury which I write out every April 15 on the U.S. Treasury to pay for my car.

There was a Cessna ad that used to run just before the first of the year last year that said, two reasons -- a big one. I recall reading it in the Wall

Street Journal. The big one, it said, two reasons to buy a Cessna Aircraft. And these were a picture of a single-engine aircraft. They run from $44,000 up to $213,000. Two reasons. I don't know what the second reason was, but the first reason was because the IRS will give you all your money back, and it explained how the ITC, ACRS, the interest deduction and so forth would buy you a Cessna single-engine aircraft.

This year there will be $424 billion in that kind of revenue foregone and/or tax spending. So that is a second way we, as a society, spend money.

George Bush is in the 12 percent tax bracket; I'm in the 50 percent tax bracket. Why? Because he bought an apartment house that's going down the tubes in Houston. What's -- you know, what's more important? That, the job core, soil conservation, Amtrak? Where do you draw the line?

So, the interesting thing about the debate when we get into tax reform, besides the fact that it will be sort of -- we'll reduce ourselves to utter simplicity to deal with minimum taxes and things like that, probably. The interesting thing would be if we could get the country's imagination to how we want to use the Tax Code and for what purpose.

A third way that we spend money is regulation.

You all know about that. That's the $1,894 per year added to the price of the car just in environmental, OSHA, you know, you name it. But if you want to get some good done for society and you want companies to do it in the way they produce products, then you add a set of regulatory requirements to everything that we do. Everything from equal employment opportunity to you name it. But that is a way to spend on public services.

You want an apartment building to go up in Houston, you give George Bush a tax incentive to invest his money in an apartment building. If you can't do that in order to buy helicopters for the Army, well, then you have to appropriate the money directly. If you want clean air and water and so forth, you do it in a regulatory process that frames up the way in which we discharge or emit pollutants into the atmosphere.

The fourth way, called restraint of competition, that one is well known in this room, I'm sure. The most costly recent example, of course, has been the automobile industry where we saved 26,000 United Auto Worker Jobs at $23 an hour and added about $1,300 to the cost of every American car that's out there for sale right now, or $1,300 to the Japanese car and $800 to the American car or something like.

But we did that. We saved those 26,000 jobs. We

enabled the top brass in the automobile companies to make themselves very large bonuses, and we did all that by just adding indirectly $1,300 to the price you pay for a car. That is, while it's not an explicit tax, it is a way to spend money. It's a way to get people to spend money for a particular purpose, which was to save an American automobile industry and to raise again the price of buying America's cars.

Now, the fifth and the last way that we all remember -- I think we remember it. There's a temptation to forget it -- is the legacy of my parents' generation to my generation and that is -- that's the legacy of having without paying for it. Most of the folks in this room have been raised on $500 homes in the suburbs, cars that don't cost anything, education that doesn't cost anything, health care that is free -- absolutely free.

I don't have to go through the housing example with most of you, but I started out with -- living with my -- about an $8,500, three-bedroom home with recreation room, fire places, et cetera, that was able to buy for $500. And when the generation ahead of me made the decision that I should have a home for nothing, the problem was that everybody who still wanted a home stood up with their $500 bills and we found out there were twice as many people who wanted homes as there were homes.

So, the old law of supply and demand went to work and we had to raise the price of everything to get those homes built, which raised the value of the folks that already had homes, so in a couple of years I could sell my $8,500 home for $20,000 and I could put $11,500 in my pocket, put another $500 down and buy a $25.000 home, which in a couple, three years I could sell for $50,000 and put $25,000 into a new business or something like that, and you know the story.

And we did the same thing in health care. We had first dollar coverage on our insurance policies and you go to work for Honeywell and I think it's practically still the same way, although they keep trying at Honeywell to brake the link. But go to work for Honeywell and here is your insurance policy. You don't even look at the damn thing. It's just a license to steal. You get a little ache or pain and you go off and see the most expensive doctor in town.

People wonder why we got too many doctors, hospital days are $500. Because it's a free lunch. You've got more people demanding services than you've got people delivering services. So what happens? You get more doctors, you get more hospitals, you get more everything. Very simple when you have the opportunity, as we all have now, to sort of look back on it.

There was nothing wrong -- there is nothing wrong

with any of these five ways of spending money in and of themselves. Direct spending you need because there are a lot of things that you can't get people to pay for themselves. The indirect spending through the Tax Code you need because America has had only -- income is the only thing that we've taxed as a national tax. We refuse to tax consumption, so you're just sitting there beating the hell out of income, and so you have to get some loopholes in that thing or people won't invest. They won't go to work. They won't do those sort of things. So you have to create those sort of loopholes. There's nothing wrong with R&D tax credits or ITZ or any of that sort of that stuff in an of themselves.

The same thing is true with keeping the competition out. My hog farmers all want me to keep Canadian hogs out now because they're 36 cents -- a dollar cheaper than American hogs so we ought to keep them out. So, if I want to same the hog farmers, I guess I ought to keep them out.

Well, I don't -- but, you know, that is the way we do it and we've done that. We obviously got telephones all over the country and we got lots of things all over the country just by taking money from long distance calls and subsidizing the farmers hook-ups and all that sort of thing. We did it with the trucking industry and -- this has been a

part of our society for so long that you can't knock it. I mean, it's just has been an important part of the development of America.

But today I guess the consensus is that everything that we have to have is starting to cost even us too much, and it's gotten to the point where we refuse to invest in anything new. You want to do something in preventive health care and you can't do it because the acute care system just costs too much.

YOu want to deal with acid rain? You can't do it. I'm sorry. You can not deal with acid rain because we don't have the money to do it. You cannot rebuild leaking water mains in New York City because we just don't have the money. The country is $25 billion a year in debt. You can't do it.

And that's the current generation which has all these wonderful things, you know, that we have built for ourselves and we're complaining. Now, what the hell do you think about your kids. What the hell are they going to say. What's Jim's generation going to say when they look at the bill that we have totaled up for them. They don't believe -- I was getting off an Eastern Shuttle Sunday night in New York and apparently the guy sitting across from me was Bill Hoover, who runs the National Senior Citizens something, and he's madder than hell at me. Criticizing me because I voted

for 3-3-3 on military defense; criticizing me because I voted for the freeze on social security. He's madder than hell. And he says, on top of that, he says, you've got this organization called AGE, the Americans for Generational Equity, and you're trying to pick on the old folks, and some young kid -- looked like a lawyer from New York or something, about 26 or 7, said, you know, he says, well, how come he's picking on you? I said, well, I'm a Senator and I voted to freeze social security. And he says, well, let me shake your hand.

(Laughter.)

He says, I'm getting tired. He says, there isn't even going to be any social security for me.

(Laughter.)

So I let them fight and I got off --

(Laughter.)

That's sort of the larger reality I think of what we're dealing with and I would hope and pray that some day Ronald Reagan, or his successor, will come along and sort of ask the country to look at these issues we're dealing with in that larger kind of a context because only when we do I think we are going to make a lot -- we're going to make a lot of sense in this place. And up until then, though, we will do a fairly average to middling job, like we did on the budget. I assume when we head into tax reform we'll do one

of those average to middling kind of jobs.

You will not get a new national tax system. You don't have to fear that, because we can't -- we can't do consumption taxes because the President says we aren't going to have any new taxes. So we won't build a new tax system. We will just go ahead and pick on the old income tax system. So your reform will be relatively limited, and I imagine you ought to stand up for your tax breaks and don't apologize for fighting for your little piece of the action because I think it's too early to try to be a hero.

And so, in the end, we will end up with some kind of a Bill Roth business, transfer tax, or some kind of an import surcharge or God knows what. It will be some artificial across the board treat everybody alike, make them all pay taxes kind of a so-called reform, and we will probably put off doing kind of a new national tax system. And until the people that you all report to sort of wake up to the fact that that sort of tax system -- a new tax system is needed in this country, not just reform of the old income tax, we probably aren't going to get it.

Obviously -- I've said it three times now -- I believe strongly we have to tax consumption. We just have -- we've got to get part of the burden off of income and over on to the sales and we have to take part of the payroll tax over there with it, or something. We've got to get

everybody in this country paying part of the cost and we've got to get people that sell products -- imported products in this country to pay part of our social insurance costs in this country. They're getting a free ride on us right now. All of your competitors are getting a free ride on this system and it ain't fair.

But I just don't see -- as long as Ronald Reagan is President, I just don't see him doing that. So, you know, I guess I say to you that if we had done Treasury 1 and we stuck with Treasury 1, then maybe you should have sort of gotten on the band wagon and said, hell, we'll all take our pain and let's just go do it. But I don't think we're going to do Treasury 1. I think we're going to do a kind of a fall back, and if we fall back from really bold reform in this country, then I don't blame you for -- I mean, even though it will be hard saying no to you when I see you standing around the Finance Committee and so forth, I wouldn't blame you in the short term -- if this thing doesn't look really big and doesn't really look like it's going to turn things around, I wouldn't blame you for sticking with your hearts of the tax expenditures.

I'll be glad to respond to anybody's questions.

Yeah, John.

VOICE: Do you think we might be able to get a Republican Senate by 1988?

(Laughter.)

SENATOR DURENBERGER: It depends on your definition. I hope we still have one by 1988. I think the miracle the other night was we lost only four people. You know, the gang of five or gang of six, whatever it is, wasn't' to be seen. I mean, Lowell Wicker was -- once he got his NIH grants and he got his Small Business Administration -- was there on every one of those votes. Kind of different.

What was implied by your question?

VOICE: Well, I -- you know, you roll the same way. You lose Pennsylvania because of Amtrak, you lose this one because of (inaudible). You can't (inaudible) --

SENATOR DURENBERGER: Let me let you finish.

VOICE: If we don't start with the Senate, we sure as hell can't start in the House, and it looks like we might have a chance to start (inaudible) that you've just discussed.

SENATOR DURENBERGER: Okay. Well, let me react to that in two ways.

One, we got rid of 12 programs. We probably could have got rid of some more. But the Amtrak debate -- if you were there, and it was very short. It lasted only 30 minutes -- illustrated the problem. Bill Armstrong said nothing -- we shouldn't run any public services in this

country that people who use them can't pay for. Joe Biden got up and said, fine. You want every Colorado farmer to pay for their water? Bill said, chuck-ta-boo, well, I suppose. So we got off the hook because we weren't voting on Colorado water. But if we had been voting on Colorado water, he'd have found a different rationale, just like they did last year when we saved -- when we saved hydro power in California for Paul Laxalt and Barry Goldwater. They get by for one-tenth of the cost that you pay for electric power here. We save that for them.

Now, what I'm getting at is simply that some things are in the national interest, you know, and I happen to believe this country, if it would stop subsidizing automobiles as much as it does, might get a rail passenger system without subsidy. But as long as we have these huge subsidies for the car, it's -- you know, it's kind of tough to get a totally private rail passenger system because it's too attractive to fly airplanes and it's too attractive to drive your car.

But I believe in a national rail passenger system, so I'm going to vote -- always vote to hang on to Amtrak. That's my signal. When I go to speak to the Committee for Economic Development here in a couple of minutes, I see they're for saving the Job Corps. I mean, they have a report on education. This is your folks that

you report to, you know, and their report on education says for the drop out -- the kid that's already dropped out of the system, there isn't a better thing in America than the Job Corps for bringing them back in.

So, how do you want me to vote on the Job Corps? I happen to have a damn good one in Minneapolis/St. Paul that's working. The problem is half of them don't; half of them do. So what do we do, close them all down and just let the good ones go?

And I think that's the point to which we've gotten now. We've gotten -- there isn't a lot of fat left, other than in defense, to get out of the system. And the fact in defense is not the General Dynamics stories or the Sperry stories or the toilet seats or, you know, any of that sort of thing. It's really -- it's in the Pentagon. It isn't out there in the so-called military industrial. It's the fact that we're still operating on a -- what is it, a hundred and fifty year old model. Everybody has to have an army and everybody has to have a navy and they have to have, you know -- we haven't thought about restructuring the way we defend ourselves.

VOICE: Senator, one of the issues that's cropped up here in the past couple of weeks is that of the minimum tax, corporate minimum tax. How do you feel about --

SENATOR DURENBERGER: Well, I oppose that sort of

thing just as -- sort of in principle, but I suspect there's going to be one. It falls in the fairness, simplicity category. When I predict that we won't do real, genuine tax reform, I would predict that we will try to do some kind of an across the board -- make everybody pay their taxes.

It's so much easier for politicians to do that than to deal specifically, you know, with loophole by loophole expenditure by expenditure, enhancement by enhancement, whatever we call these -- whatever you call these things. So, I would think that the possibility of a minimum tax is a very real possibility, but personally I don't like it.

VOICE: The problem that we have is that most of the folks include the R&D expenditures as one of the preference items and our industry is unique in the high amount of money we put into R&D and throw that back in (inaudible). We end up, even though we're (inaudible) taxpayers, paying more in income tax.

SENATOR DURENBERGER: The thing we ought to worry -- the reason I -- if it were a one-time deal, one year you pay a minimum tax -- we haven't figured out how to freeze tax expenditures this year. We froze everything else. We don't know how to freeze tax expenditures, so we'll do a minimum tax. Once, period, then get rid of it. Then we could all support it.

But once that damn minimum tax is in there it's going to stay there and it will then be an impediment to doing good R&D tax policy or doing something else, and that's why I don't like to see it even get in there. If we could put it in with a one-year life or two-year life or something like that and say it's only going to last for two years because it's a form of freeze and then we get rid of it, then maybe I'd support it.

VOICE: Senator, it's more of an observation. You made a comment that at the Chairmen's meeting the other day that there was concern about the business community walking away from the budget crunch.

SENATOR DURENBERGER: Right.

VOICE: I don't really see that, based on what I've been picking up through this Business Round Table and other CEO-type organizations because I believe that most CEO's think that the deficit issue is probably the largest cloud that hangs over the economy right now and that if you start to focus away from that, that will bring the whole house down prematurely -- economic house down in this country.

So I would hope that --

SENATOR DURENBERGER: Bill, all you've got to do is be over there lobbying on the House side then.

(Simultaneous conversation.)

VOICE: I think they're going to do that.

SENATOR DURENBERGER: Okay.

VOICE: I think you're going to see a lot of support for that and I think that the other message is that while many of us are hired to be the special interest of our companies in working on (inaudible), the CEO's seem to be more aware of those broader issues and the climate is there I believe for some restructuring that the President is talking about and some of you have been talking about, and I just would have encouraged more rhetoric coming from leadership on that. But I you'll find the business community coming in behind you.

SENATOR DURENBERGER: Great.

VOICE: I have a question dealing with employee benefits, which is an issue that I think many companies are concerned about but it often doesn't rise to the first one or two, and I'm specifically interested in your views on the health proposal that seems to be coming out instead of a cap, which you favor, they're going to tax the first $10 or $20 of health insurance and then that's it.

SENATOR DURENBERGER: Yeah, I hope to God that never passes. I mean, that's just -- that is sort of Packwood's price for getting Treasury 2 on the table. Bob does not want tax -- fringe benefits tax at all, so he in effect forced the $300 minimum tax on everybody. It's

ridiculous. I mean, you might as well just add the payroll tax -- add something to the payroll tax. It discriminates against the people with a little plan and it favors the people with the big plan because there's no incentive not to keep building your health or your other fringe benefits.

The purpose that I -- the reason I support the cap at the other end on the health side is simply for health policy. I mean, if we can force Chrysler and some of the other people to do cost sharing on their health insurance plans by limiting the tax-free income, the $250 a month on a health premium, then we've done a good because we forced those United Auto Workers to pay part of the cost of their health plan.

So, my support for the cap is only from that standpoint. Now I've added a second one, which is equity. There's 32 million people in this country that don't have any insurance -- or none of my farmers have any insurance, but Lee Iacoca gets $3,300 a year paid for him by the taxpayers so he can have free health insurance and that's not fair. It's just not -- plain not fair.

So we have a new argument for the tax cap, but even at that I don't -- I think what we ought to be doing is looking at fringe benefits positively. So I proposed yesterday -- (end side one)

-- don't put a cap on education or -- I think we

have to put one on day care. But don't put any cap on anything. Just -- the young people don't want to buy retirement -- well, retirement is excluded. They don't want to buy certain things. They want to buy something else. Maybe they don't want to buy that much health insurance. The older folks want to buy more health insurance.

Let the employee and the employer work all those benefits out among themselves within a total cap as far as the tax-free income for the employee is concerned.

VOICE: Senator, I know you have to go.

SENATOR DURENBERGER: Yeah, I guess I do.

VOICE: One last request.

In terms of trade legislation, import surcharge, are you going to say anything along there? How about Japanese trade restrictions? That's come through your committee.

SENATOR DURENBERGER: Well, I'll tell you, what Danforth is doing on behalf of most of the rest of us is what the Administration isn't doing, and that's just trying to get some equity into the Japanese in particular and into other people. I mean, the Administration does not have a trade policy. They don't want to have a competition in the trade policy. They are not doing what they ought to be doing vis-a-vis our competitors, particularly in the lines of business that you all represent, and so largely, what

Jack is doing on behalf of everybody in this country, is trying to beat up on the Japanese so that in effect the Congress will work out some kind of a fair trade arrangement with the Japanese because the Administration isn't willing to do it.

And that's sort of the bottom line of it, of Jack's effort. He doesn't dislike Japanese and that sort of thing. He just doesn't see the Administration doing what they ought to be doing, and Spencer can tell you guys from Honeywell, and probably already has, even though he's a free trader, that he agrees with Danforth on that.

The import surcharge I believe is dead, although could be -- you never know, it could be resurrected. But hopefully it died and will stay dead.

Thank you all.

(Applause.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

6/6/85

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VOICE: Well, thank you for giving me the opportunity to be here this morning and thanks also for letting me hear part of the first speaker talk about what happens when you let your mind wander and he's wandering to national PPO's and HMO's and the National Sisters of Mercy Organization and so forth. That's better than some crowds I'm in where they're wandering towards Sears Roebuck taking over this business, General Motors, now that they've taken over the defense industry, will probably take over using ESP or ESD or whatever -- organization is. Probably take over health care.

So, I'd like to start my comments by saying the obvious -- instead of the introduction -- that I'm from the government and I'm just here to help this morning.

(Laughter.)

If you please that, you'll respect me in the morning.

(Laughter.)

In that introduction you would have found out that I'm also Chairman of the Intelligence Committee and that would have come as a surprise, not to those of you who know me, but to those of you who can't believe the United

States Senate would have a committee --

(Laughter.)

But I am, and last week in that capacity I spent six days in Central America and I'm still recovering from that. During the course of this day, besides marking up in Finance Committee, at 9:30, a bill that I'm the author of on imputed interest, we have to start on the so-called Contra Aid Bill of which I'm also a co-sponsor, and at 2:30 I have to watch my last of four sons graduate from high school, which will really be the highlight of the whole day. And somewhere in all of that end up talking to the Maryland Hospital Association.

So, nice to start out with a bunch of people who ask questions like how do you know you're going to have 4 percent and 10 percent. I think that's kind of -- that's a lot more practical than Contra Aid and perhaps even more practical than watching your son graduate from high school.

But I'm going to try in a few minutes to not let my mind wander too far, try to stay in some sense of reality or predictable reality, and then to close my mouth and open my ears and listen to your questions and try to give you some responses. The reality is that you would not have had this kind of -- you know it, you wouldn't have had this sort of meeting even three years ago, to say nothing of six years ago when I came to the United States Senate. So you know

that on the subject of health care reform and all that sort of thing we are in the midst of some kind of a revolution.

To be able to predict where that's going to come out is absolutely impossible. I am in the course -- in fact, I am here as a courtesy of my publisher this morning. I am in the course of writing a book on the subject. And Bill asked me on the way down in the escalator, he says, how is your book coming? And I said, well, I'll tell you, the last time I talked to the editor he said, Senator, you are not writing a newspaper. You are writing a book. Stop giving me all this information. We've got to stop so the book can come out.

That is the problem we are in. You ought to have these conferences every week because every week something is changing and it's changing somewhere around this country and it's changing so quickly because, folks, it's the market place at work and it is consumer choice at work, and the predictability of that is something that only a politician would take on. And since I'm not a typical politician, I will not try to take on that effort today.

I was committed to consumer choice in the market place because I saw the start of it in the Twin Cities when I was just an ordinary citizen like you all are, and I brought that philosophic notion to the Finance Committee and to some of the reforms we are engaged in and with the help

of a whole lot of you and lots of other people around this country we are now in the process of letting the market go in the delivery of health care.

Now, does everything we do here make a lot of sense? Of course not, or I wouldn't have started with "I'm from the government." If you look at the latest issue of the Coopers & Lybrand Health Legislation Washington Newsletter you're not going to see a lot of market places work in there. You're not going to see an awful lot of consumer choice at work in there. You're going to see some fraud and abuse amendments, which we've been at forever. You're going to see the more prospective payment issues. That's strictly a regulatory kind of an approach. You're going to see -- oh, you're going to see the start of a change in graduate medical education, which I will describe. Rule on peer review organizations.

Now, why does a market place need peer review? Payment limits for home health visits. Somebody in government is setting the limits on health -- home health visits. Is that the market place at work? It doesn't look like it. A state reimbursement control system, does that sound like the market place? Record keeping requirements? No, none of that sounds like the market place. But, it is. It's all part of the transition from a strictly no-incentive system to a system in which the consumers will determine the

shape of the medical market place.

Our contribution this year is limited and confusing. We are in a freeze mania. We are the product of the 1980 -- well, the 1976 election, the 1978 -- all even-numbered elections since 1976. We are the product of cut off their water and they'll change the way they do business. That's what we are. We are the product of freezes and we are the product of balance the budgets and we are the product of live within your means and we are the product of years of fraud, waste, and abuse.

So, what you see this year is an effort to freeze spending in place and to do tax reform without giving us any more money to spend. That's mainly what's going on around this place.

That's being driven by a variety of different forces. A lot of well-intentioned citizens who just want to cut off our water in order to get us to do things differently. Some people want to get rid of government. A lot of people in this Administration in particular do not believe in government, particulary the national government. They believe in school districts and things like that, but they do not believe in a national government for purposes -- any purposes other than national defense. So there is a variety of forces at work. But the bottom line is try to get that deficit narrowed without raising taxes. So, when

you look at what we're doing in Medicare-Medicaid, in effect the freeze process is in place where reform should be.

Now, the reform that got set up through the prospective payment system contemplated that hospitals in particular would be able to live with some amount of inflation built into the prospective payment system. We wanted to do that because we needed to hospitals to turn this whole system around. They had half the business. They had all the doctors there. Everybody was focused in on the hospital. That's the core of all the activity.

We saw the hospitals changing from buildings to health care institutions. We saw them out-reaching, trying to get some business. Hell, nobody was coming into the hospitals any more. They had to reach out and get other lines of business. So they became community health centers in the larger sense. But that was the place to go to turn this system and out attitudes around. And so, those of us who are the reformists wanted to see the hospital not penalized for doing good.

The freeze, however, says for one year you don't get penalized. Please don't look at it as a penalty. It's just something we're all sharing in except rich old folks and the defense department.

(Laughter.)

But, it's the freeze. You do not get your CPI

this year. And so the freeze is in place and the freeze is going to stay there, and pray to God it's only one year -- and I don't mean to suggest by that that it might be two years -- but that's why the freeze as you all know it.

Part of the things that are related to it, of course, are changes where we may have been a little rich in our exemptions from the PPS. Indirect medical education is one of those. The indirect medical 11.79 percent reimbursement was -- we didn't have a severity index. It recognized the fact that a lot of teaching hospitals had the most severe kinds of cases so we had that for them. What we have found out, of course, is that a lot of them are in fat city. I'm sure any Sisters of Mercy Hospitals are included in there, but some of them are in fat city.

And particularly with the proportion of residents and interns to beds in the hospital. At UCLA that proportion is 1.0, at the University of Minnesota it's .43, at the Mayo Clinic it's .33. Meaning, at UCLA they get 112 percent of the average reimbursement, at Minnesota they only get 43 percent and at Mayo they get 33 percent. Now, having mentioned two institutions in my own state, I want you to know it's going to change and not because we have anything against UCLA, but it's just a matter of fairness.

If we don't want to go along with the Administration dropping indirect all the way down -- cutting

it in half, we'd like to stop half-way down. Like take it from 11.59, or whatever it is, down to 8.7. Stop there for three years. We're going to have to inside that do something about the unfairness in the resident intern to bed ratio.

The other thing I told Chip this morning, I thought we ought to do something about, as we are working our way in July toward reconciliation, is do something, if we can, about disproportionate share. Do something about the hospital in downtown Chicago and some of those really tough places where the legislature in a State like Illinois is not capable of realistically dealing with the problems of the indigent in the State of Illinois or in the State of Minnesota or in lots of other places.

So maybe, as we go through the changes in indirect, we might also be able to work in something on disproportionate share.

On graduate medical education, you're probably aware, and if you aren't you can read about it in this publication I just cited. I hope you can. I didn't read it, just looked at the first page. You've all seen this? Everybody here subscribe to it? Okay. Some of you get it free. It's a fringe benefit, free of tax.

(Laughter.)

Now, yes, we're going to tax this, too. You're

right.

(Laughter.)

Well, we'll have a health exemption. The tax stuff we're going --

(Laughter.)

Put this one on tax topics --

(Laughter.)

That's the one we're going to tax.

But in there there is something -- at least on the headline it says Medicare Supported Graduate Medical Education. That will tell you about Dole-Durenberger-Bentsen, on which we had a hearing, and I think that's the first step in explicitly dealing with graduate medical education. In effect, we say Medicare should pay for its proportion of graduate medical education, but we need to do something about the over-specialization of American and the over-education of the doctors in this country.

But one the things -- what we in effect say is that we will pay our share of graduate medical education up to initial board certification or five years, whichever is the least. That means that if the reconstructive surgery or plastic surgeon folks want to give you seven years, they've got to figure out some way to pay for those extra seven years in order to turn out guys that can remove moles or something like that. I know they do other things besides

remove moles, but somebody, other than Medicare, ought to pay for some of those extra years that a lot of those people are piling on there strictly for economic reason.

So, we stop at that point and we will explore as a society where and how we're going to deal with certain of the medical specialties that require going beyond that particular limitation. Again, government is not trying to tell anybody what to do. It's just trying to deal explicitly with a problem that up to now has not been faced because it's all been hidden in somebody's health bill. Nobody has paid for graduate medical education in America except health insurers and the sick. From now on you don't want to pay for it explicitly. In an explicit sense, we have to find a way to say this is what society will contribute to medical education. Then a market place ought to work to redesign the way we educate the health professional.

Among the other issues that you may see on reconciliation this year could well be something that I've been working on which is to recognize the fact that when we put the prospective payment system into effect for Part A of Medicare we recognize there are probably a hundred different procedures out there that shouldn't be done on an in-patient basis in the hospital. I can give you cataract surgery as one example. We're forking out $3,000 or $4,000 per when,

an Australian ophthalmologist told me a couple of months ago, in Australia they pay $170 for the doctor and the room in which the operation is performed. But in America, we pay out $3,000 or $4,000 for that in the hospital.

Well, we forced it from in-patient to out-patient in the hospital, but they're still getting their -- somewhere between $1,500 and $3,000 for a procedure that ought -- that can be done in an ambulatory surgery center for a whole heck of a lot less.

So, there are a hundred procedures, approximately, that may or may not fall in that category. What I'm trying to do is design a realistic reimbursement system in Part B for those -- so you can go and do it in a hospital if you want to do it in the hospital. There's nothing wrong with that. But you're going to get X-number of realistic dollars, and again, the market place should work to reflect that.

One of the things we won't do this year is capital reform. We're going to do that -- not in Health Legislation Newsletter, we're going to do that one in Tax Topics. Anytime we do health policy over on the tax side, you ought to watch out. That is one where I sincerely cannot be predictive.

In the short term we're trying to decide between a couple of related approaches on tying a -- tying capital

in with the current DRG system, and it's either a specific add on where we take -- the hospital is specific about it. If you're at 22 percent you gradually come down to some other percent, or 13 and you gradually come down. You can't just hack people off. Or you work some kind of a fold in or blended kind of approach, which I can't even explain to you, that HHS has been working on.

But if we could get that part of it, just the DRG related part, done in July, we will try to do it. If we can't, it may come on a tax bill in November because we'd like to decide the issue of the capital -- moving from the capital pass through to a DRG add on. Get that decided sometime this year because it has to be decided by October of next year. The larger capital issues however are in Tax Topics. That's where you get into the really big issues. Tax exempt bonds being one of the largest of those issues.

I am a great proponent of private placement tax exempts, principally only because my state uses them more creatively than any of the other 49 states. Do I believe in them? No. No, I do not. I believe there ought to be a distinction someplace in the market place between taxable and non-taxable bonds, and that distinction today has been blurred by the proliferation of the private placement tax exempt, plus a lot of other factors, but it's blurred. That means the local community, on behalf of its sewer, water,

highway, whatever it is, public purpose, really doesn't have a market place leverage against a lot of other instruments that it ought to have.

So if you ask me in the real world what would I like to see, I would like to see the old general obligation bond financing for pure public purposes. Now, does that mean only go to government? No, of course not. It means that if we qualify health as a public purpose, then that gets a general obligation or a tax exempt status, and we'll have to debate whether or not we put health in that status. If we do, then the for-profits go in there, as well as the not-for-profits. I mean, everybody is going to be treated the same, and the fact that you are a government or a non-profit or a for-profit should not make any difference in your access to the capital market.

If we want to give people in the government sector a break, give them an explicit break, not a hidden break in terms of their dollar access to capital. I think that's one of the lessons that we should have learned from the multitude of subsidies that we have built in to capital investment over the last 15 years.

Where are we going? Lord only knows. Where are we going in tax reform? I don't -- probably the Lord doesn't know. I didn't ask him this morning.

(Laughter.)

If he's smart he's staying away from that sort of an issue. He's also staying away from the taxation of fringe benefits, I would imagine. That is an issue in which I feel fairly strongly and I've shared those feelings with some of you from time to time. The compromise that Treasury had to make with Bob Packwood on health insurance, they won't acknowledge it except privately. It was just a ridiculous kind of a compromise to tax from the bottom up. It doesn't really do anything except to impose a tax on people who go to work, and it's unfair because Lee Iacoca will -- you know, if he's taxed $25 at the bottom at Chrysler, he's just going to add $25 at the top tax free under the current program. He's going to be fine.

But my poor, little, small business man back in Minnesota who can only afford -- or his employees in a little shoe store in Greenbush, Minnesota, they can only afford $100 -- basic coverage for $100, they're going to get $25 hacked off the bottom and they aren't going to be able to afford to add $25 to the top, even if it is tax free. That's such clear discrimination I can't understand why the business people in this country don't understand it.

I mean, when I was in Detroit, you know, the -- Paul Brouton asked me -- from Children's -- he said, you know what the biggest killer of Children was last year and I said, no. He said, poverty. And I'd never thought about

that. Ten thousand kids died of poverty because Iacoca has got to get $3,300 from the taxpayers to go with his $2 bonus. It ain't fair, gang.

Nobody's designing a scheme to take away the protected nature of your health benefits. All we're saying is cap it at $250 a month -- $250 a month -- and maybe if we do that we'll get that -- start to get that deficit down and maybe we will enable Detroit and the State of Michigan have the courage to spend a little more money and maybe we'll even get the courage ourselves to same some of those 10,000 kids. It isn't fair, but it's happening.

That is all the tax cap -- there's one other thing the tax cap is about and that is tax share -- I mean, it's cost sharing. But you're doing a lot of cost sharing already, except at Chrysler and a few other places. But why let them off the hook. If this is the period of fairness and simplicity and equity, why do they get to keep their first dollar coverage at the taxpayers' expense when all the rest of you are paying high deductibles and all the rest of that sort of thing. So that's the reason we'd like to see a tax cap.

Now, what would I really like to see? I'd like to see a cap on flexible benefits. I'd really like to see cafeteria plans all over: little people, multi-employer groups, all that sort of thing. Lots of cafeteria plans.

Let everybody have a choice of what kind of benefits they want. Don't have the government tell you which benefits you ought to have by saying, well, we'll only give you so much dependent care and we'll only give you so much life insurance. The hell with it. How do we know? How do we know? Young people want this; older people want that; folks with big families -- by the way, the tax bill says your families ought to get much bigger in the future.

(Laughter.)

And the women better stay in the home, too. That's what the tax bill said. I didn't say that.

(Laughter.)

You know, that is the -- I forgot where I was headed. That is the reality I think of where -- what was I talking about?

(Laughter.)

The first time this has ever happened. I know got off on the tax cap and -- I was on cafeteria plans and putting a cap on the -- this Q and A thing we went through last -- you know, a year ago February and then we went through -- it was really kind of ridiculous.

And I think we might be surprised with the help of some people in this room who I know are working with us. We can create a realistic cap on the non-401-K non-entitlement, non-retirement pension, et cetera, benefits.

We can put a -- I guess right now we're looking at a $2,100 cap for individuals; $4,200 for families, or something like that, and then just let the employer and the employee run within that kind of cap. Then we get the fairness and we also get all of the benefits of consumer choice within that cap. So those are some of the things that we're looking at to do either in the health care reconciliation in July or in tax reform.

Some of the things we may not be able to take on are the restructuring issues. I wish we could means test Medicare, but I don't see that coming in the near term. We would like to do something on a -- what I call the poor man's HIRA, or health incentives reform act. In other words, find a way -- and we found a way and it's in and I don't have the bill number in front of me. Find a way to give the self-employed people the same tax break that we give employed people. Give them a $250 a month cap for a family plan and a $100 a month cap -- but give it to them in the form of a tax credit so that they have the same benefit that everybody else had. I wish I had the number of the bill. Maybe somebody can give it to you. Maybe it will be written up in the next issue of whatever this is. But it's a good thing. Give everybody the same benefit. The problem is it's going to cost a little bit of money.

In exchange for the tax benefit we're also going

to insist -- and I don't know whether we'll get this done in reconciliation -- on a year's continuity. The widow, the divorcee, the 19-year-old -- 18-year-old child, whoever gets cut off the health plan ought to have the right to buy into the employee or former-employee's health plan at at least no more than 110 percent of the group average for that person. If we could do some of that kind of continuity, we can avoid health care for the unemployed sometime in the future.

By the same token, we'd like to insist on catastrophic. We've defined catastrophic as everything over $3,500 a year out of pocket. We would, in effect, mandate continuity and we would mandate catastrophic in all of your health plans, otherwise you don't get the benefit of the special tax treatment.

Those are the kinds of things that are on the front burner right now in this place and I don't know that -- I think it's appropriate to stop at this point and I may have missed an issue or two or three. But somebody in this room will have spotted the void by now. Not you. You want to be the first?

VOICE: How about national versus non-national rates for people? Are we going to get the national rates or are we going to pull back?

VOICE: The question is about the future of the prospective payment system and how soon will we get to

national rates if we do get them, the national rates.

As most of you know, we have several things going on the future of PPS. One is to get a capital adjustment built in by October 1 of next year and then to get to national averaging, while on the outside we were supposed to be considering a severity index which would replace all this urban-rural stuff. If we had a severity index, we don't have to do the artificiality. We aren't close yet to a severity index. We can see it, but it hasn't really taken shape.

We also wanted to expand PPS to include the docs, the skilled nursing facilities, home health and hospital. We're part of the way down that road. We think we're close on skilled nursing, but we haven't got anything in hand. Maybe we will by July.

On the docs -- I'm expanding on your question. On the docs, again, we've got a lot of good information. We've got some clues as to what we ought to do. I think one of the things we know we can't do docs just as an add on on DRG's. We can probably do surgeons and surgical settings as an add on to a hospital DRG, but beyond that we're going to have to go to something like the old relative value scale for the doctors.

On the national average, I would guess that if we don't make it in the year we're going to make it, we're

going to make it in the year after that. We -- at least I will resist as strongly as possible anything more than a one year delay, and only that if it is forced on us. I recognize the regional differences and so forth, but I don't believe that in the long term they have to exist at the rate that they do exist. And I think changes in physician practice patterns are important. More conservative practice of medicine is coming in in a whole lot of places. The changes that have to take place even in the regulated states are starting to take place.

So, the pressure will be on -- at least from this quarter -- to get to a national average as quickly as possible. We obviously are not insensitive to the consequence of that in certain parts of the country and so there is a constant search for what do you do by way of temporary or transitional exceptions. I know one of them is not to continue the process of granting New York, you know, a waiver or something like that and letting it go off and do it's own thing in the total sense.

Now both -- I guess the hospital associations in both New York and Massachusetts no longer favor the waiver. Lots of other people do. And I'll go up and find out what Maryland feels about it.

(Laughter.)

Did I answer that question?

VOICE: Yes.

VOICE: Okay. Somebody else, I know, has a question.

VOICE: What are (inaudible).

VOICE: Physicians?

VOICE: Yes.

VOICE: If you're -- the question is when are physicians going to be denied payment in the way hospitals are now.

Are you talking about the early -- pre-admission screening process?

VOICE: (Inaudible.)

VOICE: Yeah, the -- if I understand what you're asking about, the PRO just makes the determination that it was an inappropriate admission. Then there is an appeal process, and I haven't heard the last percentages, but in the beginning of course there were a lot more denials than there should have been so that a lot of those are coming back and being taken care of.

I don't know that there is as yet the necessity to do that with regard to physicians and/or outpatient treatment. That is a matter of where, in what setting a particular treatment ought to be provided. Almost more than issue of whether or not there was an illness or something like that involved. That usually comes up in the issue of

whether a person should have been admitted to a hospital when they could have come in to the doctor's office and been diagnosed for a much-lesser illness than the doctor thought they may have had when he was doing his diagnosis over the telephone.

So, when we get to a more thorough analysis of what is happening in Part B as a result of the DRC screw down on Part A, that is the point at which I think you can expect to see us, as an insurer, looking more closely at the physician. But by -- (End side one.)

(Laughter.)

-- ask me about the veterans. I think the good news is that when reform comes, it comes all over, and if we don't have to go to war in Nicaragua in the next six years, I should think the answer to your question is, yes, we will or some other place. I don't want to pick on Nicaragua. It's not a nice place to go to war.

The reality is that the current veterans -- the current system was a mistake. It's acknowledged by veterans. Not their organizations, by the individual veterans. I mean, they know it was a mistake. But we're hung up now because we have -- whatever it is -- 225 of these institutions all over the country. Got to do something with them. We also have 7,000 -- whatever it is -- residents and interns going through those places every

year. I mean, that's almost the heart of medical education in this country.

So, if you can get the medical education part of America to let go -- not all the bad guys are politicians in veterans organizations. You've got to talk to the docs in the medical colleges as well because they use these places because they're free. It doesn't cost them anything at all.

If you can pull those two things loose, I think the environment is there to transit over the next 10-15 years. Their population is now 64-years-of-age on the average. Their real needs are long term care. They're being main-streamed on long term care. The Veterans Administration is for that, the local level are for it, and if we could just make some sense out of the way we pay for long term care -- we, as a society -- more private insurance rather than all government programs and povertizing the poor and all that junk, then we'd have a healthier nursing home industry out there with a -- doing the kinds of things they do so well, but they're now crippled in doing by some of our reimbursement system.

Then it would be easy to flow the existing older veterans population into that system in which they would have -- gradually have their acute care needs bought for them also in the community. Rather than saying you only buy your nursing home services in the community, but if you have

an acute care problem you have to go to the veterans hospital. Gradually those people will be able to buy their acute care in the community the same way everybody else in the nursing home or the retirement home, or whatever it is, buys their care.

And then it's largely a matter of what the society is willing to do with those existing institutions. We probably ought to take them down. That's one of the things we have a hard time doing. That may have to come.

VOICE: What are the future of health planning (inaudible)?

VOICE: The future of health planning and certificate of need.

I would say certificate of need is -- should be gone. I know it's being used somewhat skillfully in some areas. But it really ought to be an informal process and it ought to be community based. Whatever they're doing in Rochester, New York or, you know, some of those places where it's basically informal and it's the community at work, is much better than the old imposed system.

Some communities like ours in the Twin Cities, they've taken health planning and certificate of need and used it creatively. They've conditioned the certificate on certain kinds of performance from the hospital. But you can't count on every community to do that.

So I guess my answer to it is that we will gradually relax the controls on health planning and -- at least I am very anxious to get rid of both certificate -- all the certificate of needs, including 1122, and not have that be a mechanism that's used by anybody in a governmental sense.

There was a question of here someplace.

VOICE: What is the (inaudible)?

VOICE: Yeah, thank you for that.

It's essential. I mean, it is -- the fact that you raised the question and if you hadn't been talking to the person next to you, you probably would have been the first one with your hand. But, it's a very serious problem. If you're in a state where they'll let them go up 70 percent, you know, that's serious and -- or if you're in a profession, OBGYN, or something like that, where they just -- everybody goes up because one or two people screwed up some place.

I don't have an answer to it. We're debating, as you can tell from -- watch product liability. What do we do with product liability, and from that you're going to get your clues. Now, we did not just report the taking product liability from a state-by-state level up to the national level. That failed to come out of the Commerce Committee by a tie vote here a couple of weeks ago.

So that means we are not willing to make the decision as to what the national role ought to be on setting some standards and enforcing those standards on product liability. I'm afraid the same thing is true as far as professional liability is concerned.

So we're working to try to frame up -- with Hinsonmore and some of the House leadership -- to try to frame up something that comes in the form of national standards with some kind of a requirement that the states implement those standards. If we don't implement them, the states do. We try to set the national standard.

But it's still in just the we-ought-to-do-something-about-this stage and then honestly, the opportunity is there at the state level for insurance commissioners and legislation and so forth to help you, but I think they're waiting for us to act and we are all anti-federalists I guess and we're in our traditional sense waiting for them to act.

So, I wish I could be more encouraging because this is a very important issue, and it's a discriminatory issue because different doctors, different hospitals in neighboring states have very, very different kinds of economic penalties places on them because of the litigation, the result of some litigation.

Yes.

VOICE: Would you please expand a little on the statement you made earlier regarding mandating catastrophic coverage for out-of-pocket (inaudible)?

VOICE: Yes. We have been -- the question is on catastrophic.

We have been struggling, at least since I've been on the Finance Committee, with how to mandate catastrophic on the theory that if everyone were covered for catastrophe our insurance buys, all of our insurance buys would be much more realistic. The reality is that that's the cheapest coverage you can buy and, yet, it's always the last coverage that people have purchased. They -- everybody buys the first dollar kind of stuff that they -- the stuff they know they're going to need. They leave that for the end when they've run out of money.

Well, what we have finally concluded is that the problem is not as difficult as it may appear. And so what my bill does is it says that if you want the tax free -- if you want the advantages of the Tax Code, employer-employee relationship, et cetera, or you're not in an employer-employee set up but you're self-employed, if you want the benefit of this new cap that I'm talking about, this new credit, then you're policies must have, first, a minimum set of hospital-doctor benefits -- and we describe those very briefly -- plus you must provide a major medical or

catastrophic, which means that the plan will pay for all out-of-pocket expenses or the set of medical reimbursement over $3,500 per year.

And the third thing you must have in there is that the plan will permit the purchase by a family member who has been in effect disenfranchised from the plan by death, divorce, end of employment, that family member must be able to buy into that plan for at least -- for no more than 110 percent of the average cost of that plan.

Does that answer the question?

VOICE: Yes, it does. I think it's a very good idea because (inaudible) -- especially the out-patient setting to the many patients who are under-insured and who have insurance caps, insurance payment caps (inaudible).

VOICE: I think it would be particularly important if we could get it into Medicare because, if we got catastrophic into Medicare, we'd end a whole lot of unnecessary supplemental purchases that people are making right now.

I think I'm going to have to run. So if there is more burning question. Well, you already had one.

Yes.

VOICE: (Inaudible.) What specifically does the government propose to do and how do you propose to find out (inaudible)?

VOICE: You're talking about the indigent now?

VOICE: Right.

VOICE: I'm glad I didn't get out of here without somebody, particularly a young person, asking me the question about the indigent, and I come at this not only from the health side but from -- as Chairman of the Intergovernmental Relations Subcommittee on Governmental Affairs. So I have the federal-state-local responsibility.

I think the answer to the problem of the indigent is not easy to come by. The only way you're going to get to it is through getting efficiencies in all the other -- in the long run. You've got to build efficiencies into all the other systems so that you have the capacity in your health committed dollar to deal with the problem. That's one thing I will say.

The second thing I will say is they must be dealt with explicitly. We cannot build warehouses for the poor or doctors for the poor or anything just for the poor. Now, the good news in that, if you are willing to pay explicitly -- that is, don't just say you've got to go to this hospital or you've got to go to that hospital if you're poor or you can't go anywhere. The good news is that we have now -- talked about it earlier -- in America the way to access the poor to the same system everybody else has and it's called a health plan.

All we have to do is buy him a health plan. Don't try to buy him the health care by reimbursing their doctor and reimbursing their hospital and so forth. Buy him into a health plan. And I know what we're going to end up with here in ten years is everybody in the country will have a little plastic card, or whatever it will be in those days, and that will be their health plan. Maybe it will say General Motors on it. I don't know. Or Sears. Hopefully it will says Sisters of Mercy or something like that.

But when you come to the hospital or the doctor you won't know whether that person is indigent or that person is elderly or disabled or that person is employed somewhere because all they'll have is their health plan card. It will be paid for in one case by an employer with a tax break or by Medicare out of the Medicare Trust Fund or it will be paid for by a combination of federal-state-local resources that bought that people into the health plan.

Now, the reason -- the second reason the health plan is good is that -- most of these plans are going to be prepaid plans along the HMO model, generally, because that is the efficient way to bid your services. In the long run, even though we don't see a lot of evidence of it yet, the way those plans compete with each other and stay at those 4 percent, 10 percent ratios and so forth, is by keeping people healthy.

The one thing the poor don't get today they really need -- most of them can get into an emergency room. What they don't get today is preventive health care. That's why so many of them are dying. It's the conditions in which they have to live. It's the lack of nutrition and food and it's the mothers that are giving birth to one-pound babies because nobody's told them about smoking and drinking and all the nutritional problems and all that sort of thing. That's where a lot of those statistics are -- not statistics, those deaths are coming from.

So, in putting people into some kind of a capitative plan where the provider has incentives for not letting you get into -- have to go to the emergency room is the best way to do it. How that's going to get financed is largely up to you. If you let me, at the national level, get by as I have in the past, without acknowledging my responsibility to the indigent, well, then, I'm going to say let it be up to Detroit and to Michigan.

I think that's unconscionable, but that's the majority opinion in Washington today. We don't have a responsibility to the poor. I think that's horrible, but that's where it is. I've never heard the President of the United States, for example, clearly say we have a national responsibility to the indigent. I don't think he will say that.

So that's the first thing we have to make a decision on. Then we can rearrange the so-called welfare system. It wastes money today. The idea that we buy services for people by paying checks and in kind things is ridiculous. People out to get a lump sum or they ought to get a voucher or something else that entitles them to make choices. But don't let them just walk in and send the bill to somebody in government. That's what's been wrong with the whole problem. So, we can redesign the system to make it more efficient. But the national government has to say, first, that it has some responsibility in this area.

The last thing I better say on this subject is in Medicare reform we need to acknowledge that Medicare is for all elderly and disabled persons, because the biggest problem today in terms -- for local and state government in the indigent area is that the elderly poor are going up at such a large number because people are povertizing themselves to get into the Medicaid program because that's where they get their nursing homes. So, that's going up -- like that -- rapidly, whereas health care and long term care and other -- I mean, the health care for the under-65 poor is going down in real dollars because it's the old folks that are sucking up all the Medicaid dollars.

So if we can redesign Medicare to take care realistically of all elderly and disabled and just leave the

under-65 and non-disabled to be dealt with in this federal-state-local relationship, I think that would help, too.

Thank you very much.

(Applause.)

(End tape.)

TRANSCRIPT OF PROCEEDINGS

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09-299-86

Luncheon Speaker

Senator David Durenberger

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VOICE: Welcome to the 1986 annual meeting, Council for Responsible Nutrition. "Health Messages - New Directions and New Opportunities."

This is Tape 09-299-86.

Luncheon Speaker, Senator David Durenberger.

Thank you.

THE MODERATOR: And he has been involved in a host of activities, chairing lots of committees and all kinds of things in the state.

He became involved in national politics when he was elected to the Senate in the year 1978 to succeed the late Senator Hubert H. Humphrey, and he was reelected in what I remember was a rather stormy campaign in 1982, where he persevered against the millions and the large political influence of the Dayton family in Minnesota and came through and won the reelection rather handsomely.

The activity that relates the Senator closest to our interests I think is his chairmanship of the Subcommittee on Health and the Senate Finance Committee, and I am sure that the experience that the Senator has had in health issues will be of great interest to us, and I am sure

that we are going to find an ally in the Senator in many of the issues that are important to us.

Senator, it is a pleasure to have you.

(Applause.)

SENATOR DURENBERGER: Danke schon, Manfred. Now, you can tell that everybody in Minnesota speaks like he does.

(Laughter.)

We all have a German accent. All this stuff about Scandinavians is a lot of baloney. You now have two German Senators from Minnesota, and nobody believes it, and one is Jew and one is a Catholic, and nobody believes that either. They say what has happened to Loretta Young, you know.

(Laughter.)

So anyway Hubert started it all.

I am here to share with you a few ideas. I will try to do that as quickly as I can. I am here courtesy of my stipendiary relationship I have with my publisher, which explains only that it costs you something to have me show up today and that I am going to take advantage of that in order to tout my small publishing empire, which its latest product is called Prescription for Change, and for those of you who are smarter than I you can tell when you look at this book -- after you buy it at a bargain price for all of you

-- the kaduz or whatever you call this thing is going up the wrong side of the whatever it is, and also on the back side it is supposed to read "Prescription for Change" that way, but it reads upside down going the other way.

(Laughter.)

So you only notice that when it is on your shelf and you read it "Change for Prescription," and that doesn't make any sense. So anyway you are not in the prescription business, and I am.

(Laughter.)

You are all over-the-counter just like politicians. But anyway I wanted to tell you about the book, and the previous one is even better. This is a collection of speeches, and I just happened to have found one that I am going to quote a little bit from because I think we are -- as Manfred says, we are kindred spirits in our approach to health care in this country. But the predecessor of this book is called "Neither Madmen Nor Messiahs," and that is sort of the story of the first four years of a Senator who didn't know anything about national security when he came to this town and who now is Chairman of the Senate Intelligence Committee; in fact, the first Senator from Minnesota -- despite Humphrey, Mondale, and McCarthy, the first Senator since 1931 to be Chair of a Senate committee, and I offer it to you not because of a

particular pride that I have in the authorship, but because it would be illustrative to you of the kind of people that populate Capitol Hill.

You will find many more thinking people up there than our collective enterprise would indicate, and that --

(Laughter.)

So that is and should be welcome.

Well, when I talk about health policy changes, I am fresh from passing the Henson Moore election to the Senate bill. The Medicare fraud and abuse bill passed out of the Senate Finance Committee today, and in addition to Henson Moore Medicare fraud and abuse provisions, it has about 54 other changes in Medicare and Medicaid on it, and that is one of the reasons why this book is not the ultimate book on health policy. I have been working on that one for three years, and things are changing so quickly, so fast, and so well that I can't keep up with it, and when I write a book I want to sort of have all the answers in it, and it is just that I am having a hard time getting it out.

But this, if you are interested, this will give you some idea of where we are going. The title is "Health Care Reform Through Consumer Choice," and that is what we are doing. I am going to talk to you today about the premise on which it is based, but if you just read -- and these are excerpts. You don't have to read the whole

speeches because the whole speech is not in here. I am not Jack Kemp. I am not running for anything. Or Gary Hart.

(Laughter.)

The editor very carefully took little pieces out of various speeches, and so you can go through the -- you can -- and I assume that you are one of the wonderful groups that comes to Washington because you don't come very often. Most other people are here all the time and are always lobbying us and all this sort of thing, and I am told this organization is more naive than that, and so --

(Laughter.)

-- you are all much more -- I feel better. I mean, I feel very good about talking to you today.

But if you look at the index, which you can't do because I haven't brought any other copies of this book with me, but it talks about generational equity, which is the context for change. In other words, we are not just changing health care through consumer choice. We are doing something about generational equity, the fact that my generation is about to be the first generation in history to leave its children less well off than it was left by its parent.

So in the context of what we are doing in health care reform, you have to understand is being done in a much larger -- with a much larger purpose in mind.

Why are we doing something about inflation and interest rates and trying to balance the federal budget and trying to leave within our means? It is largely because we are now on the verge of povertizing our children.

When I went through the period of time from age 25 to age 35, my actual income, my spendable income went up 108 percent back in the '60s. In the '50s somebody who made that same transition in America from age 25 to 35 their income went up 188 percent. In the '70s people who went from 25 to 35 years of age income went up only 16 percent, and in the '80s these young people's income is going down. Going down.

And yet I have taken a $500 house -- I mean, a $12,000 -- my first home was $12,000 in 1960. I think I paid $500 down or maybe I got it on a FHA or something like that and didn't pay anything down, 4.5 percent interest rates forever to pay, and I took the average housing in America from $5000 up to $96,000. Now, my children live with me.

(Laughter.)

So in the context of why are you reforming Medicare, why are you reforming the health care system, put it in the context of generational equity. Then we talk about deficits and tax reform, which are current reference points for today's decisionmaking. I mean everything.

I just came from three hours with Bill Casey and Pete Aldridge, the Secretary of the Air Force, and we were talking about the budget crimps in the national reconnaissance system, which is all of the satellites we have up there spying on the Soviets and looking for drug dealers in Colombia and watching Daniel Ortega shine his glasses in Nicaragua and stuff like that, and they are complaining about the deficits and they are complaining about the fact that in a deficit situation they can't get enough money to put a good overhead collection system up.

So whether you are talking Medicare or spies, we are dealing today here, in this town, with deficits and we are dealing with tax reform. We can talk about that in the Q&A if you want.

Then we talk about health care in transition. Pickles no longer pay the bill, you know, and I sort of trace the history -- if you are interested -- of the days when people got paid in pickles and hams and things like that for their doctor's services until they discovered group health purchases where they could group rate and community rate. Then insurance came along and employers were able to provide free insurance for people when they came to work, and they got the Tax Code amended so that it was literally free health insurance, and after that we got rid of insurance and it was just health plans, and anything you

thought of that was healthy, including your nutritional vitamins or whatever, you know, if you could find a medical reason for it -- eyeglasses, toothbrushes, whatever -- you could bargain into your so-called health insurance plan in America, and it started out at the point where people needed cash rather than pickles and it ended up where we destroyed health insurance and we destroyed our health.

See, my generation is the first to believe that it is easier -- and therefore it is something we should do -- to get sick than to stay healthy. My generation as it grew up has been rewarded for going to the hospital or going to the doctor. We are never rewarded for staying healthy except, you know, it may feel good to jog and you may, blah, blah, blah, blah, and all this sort of thing, yet there are no rewards anywhere for my generation. If you get sick, you know, your employer pays you to get sick. You know, you get sick care or sick pay, right, sick leave.

That is an institution. We were all raised on sick leave. It is an entitlement. In fact, now we pay sick leave to people that don't even get sick. I mean, you just sort of write it off when you leave the company or something. They pay off your sick leave. It is an institution, sick leave.

Get sick. Go to the hospital. Your employer will pay you. And all the idiots that stayed healthy back

at work, you are going to have to come in the evening to the hospital and say how are you getting along? Oh, I am fine, it is great here. You know, you ought to try it sometime, which is what we all do.

(Laughter.)

Flowers, cards, pretty nurses, you know, all that sort of thing. What should I think? I mean, you try to sell me wellness. Keep it.

(Laughter.)

You know, why? My mind has been trained to believe that it is better or easier, or as the case -- whatever the case may be.

So, you know, in the context of reform and all that sort of thing, look at the reality, look at what we have done. Pickles no longer pay the bills, money pays the bills, and now we have got the money protected by the Tax Code.

Then I get to something called Chapter 4, "Prevention and Wellness," and that should interest this group because it says this is the twin goals of health system reform, prevention and wellness. It doesn't say anything about more elaborate surgery or the next generation of take my heart out and give me somebody else's heart, and that sort of thing. It says the twin goals of health system reform are prevention and wellness.

Now, there aren't a lot of people in America in my generation who have ever said that to anybody. They have not said that is the national goal of health policy reform. Usually they say we want everybody to be able to get to the doctor and the hospital whenever they feel like it and without paying for it. That is what national health insurance or national health policy has meant.

Hubert was great at it. Teddy Kennedy is changing. He was great at it in his day. I mean when --

(Laughter.)

No, no, no, no. No, no, strike all that.

When he was promoting sickness, hospitals, doctors, do all this sort of thing.

But here it says prevention and wellness. There is one speech to Minneapolis Children's Medical Center entitled "Putting Our Money Up Front." Up front. The quiet revolution in health care. An ounce of prevention -- I must have picked that up from somebody -- an ounce of prevention.

In another speech to the American Public Health Association entitled "An Investment Up Front," and here is one that must be on smoking or chemicals or something called "Kicking the Habit." Well, gee whiz, I mean that is -- you know, why in the world should we bother? Why should we bother?

Well, we need to bother because we have priced

ourselves out of the things that I think we all value, which is good health. We have priced ourselves out of good health in America because we put all of our investment into sick care and it is now running away from us.

So when it got to 10.5 percent of the GNP, the public said stop, you got to knock this off. Joe Califano, who spoke to you yesterday, is kind of a recent convert to all this because when he was around he could sense, too, that the public was getting fed up with all these insurance premiums going up and all that sort of thing, but Joe could never address himself to the real cause of the problem, which was Joe Califano and Dave Durenberger or all of us.

You know, Joe would say the problem is the hospitals, the problem is the doctors. Joe is just like all the old folks in this country and a lot of people my age who want to blame somebody else. Blame somebody else for the problem. It is the doctors and the hospitals. So Joe promoted and got Jimmy Carter to promote hospital cost containment, that what we need in this country is a system in which we regulate the prices. Bull, you know. That doesn't do it. Only the marketplace works. Only the marketplace works. So that is where the consumer choice in health care comes in.

What is the bottom line of the choice? The choice to stay healthy. Choices to stay healthy with

visible signs of rewards in them and choices in preparing yourself in case of illness. That is what we are all about.

Everett Koop still reminds me all the time that the first time we ever went to lunch after he gave me a little button to encourage me to quit smoking my pipe, which I eventually did -- I still don't wear the button, and he always looks under my lapel -- but anyway he reminds me all the time that he asked me the question once, what percentage of GNP on health is appropriate, and I said I don't know. And he said you are the only one that has ever answered that question correctly because the reality is we can spend 20 percent of GNP on health in this country and if most of it were being spent on health care we would be glad to do it.

The only point is we put the halter on this system when sick care got to 10.1 percent or 10.5 and was running away with us, so we couldn't afford health care prevention and wellness. So I put that in the context again of what our principal objectives are in this whole system.

The bottom line is simply responsibility. If I am going to live within my means, I also have to be able to take responsibility for my actions. Those are the twin ills of my generation in America today, and whether you look at health care or housing or the federal budget or you go to the -- go with Bill Moyers to that ghetto in Newark, as he did on that CBS special here a few months ago, followed all

these young kids around, driving around with their boxes, talking about playing mommy and daddy without taking any responsibility for it, it is the same thing. It is a generational problem. We have been raised to believe we don't have to live within our means, and if that is true, then we also do not have to take responsibility for any of the rest of our actions.

And put those two things together, apply it to health care, and you are in the right line of business. It is just that you aren't getting a lot of help from the rest of the system.

So you may, as you go through a book like this or you get a chance to talk to a few of us around who believe in all of this, ask us what kind of principles -- you know, when we come to Washington we try to talk to Frank Young and the politicians, and so forth, about principles for guiding this change. Do we all have to be expert on DRGs and experts on all the rest of this sort of thing? The answer to that is no.

Here is eight principles which I first apparently put down in sort of principle form on September 18th, 1981, five years ago next week, or whatever it is, and because everybody ought to be able to disagree on how to do these things I thought I would at least try some principles on people, and one of the principles for consumer choice in

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health care is that choices are good and that government policy should expand choices to the individual, not limit them.

In other words, Joe was wrong. Joe was limiting -- and Carter were limiting choices. They were freezing all these hospitals in place and all these doctors in place, and in fact they were not permitting the good hospitals to get all the business or the good doctors to get all the business. They were just freezing that system in place.

Today government policy should expand choices to the individual, not limit them in any way.

What Joe is -- and I am not picking on Joe. I am using him as a calendar, sort of a chronologic reference point -- when he left office, doctors' offices were being built as clinics next to hospitals. Today they don't do that anymore. Today the doctors are in the shopping centers next to McDonald's doing same day surgery for this, that, or the other thing, expanding consumer choice, getting more efficiency into the health care delivery system rather than less.

So government should expand choices to the individual, not limit them.

Second, the government is generally a better purchaser of services than a provider of services. I often say -- and this is one thing I know nobody ever believes

when I say it -- that ten years from now there shouldn't be any public hospitals in America. There is no need to have Los Angeles General or Cook County General Hospital if everybody in this country had the same choice of health plans that I have -- I got 22 choices in Washington, D.C. through the Federal Employee Health Benefit Plan. My employer, you, the federal government, you provide me a voucher of $126 a month.

Every one of your companies does this same thing, I am sure. I should have asked somebody about the individual companies here. But every company says -- at the old H. B. Fuller Chemical Company, where I was, it was like $175 a month, only they never thought about it as a voucher or anything. They said here is two health plans and we contribute, you know, something to each health plan. If you examined it, you found out they paid $175 towards the plan of my choice.

So you take that and you transpose that to Medicare, which we are now doing through competitive medical plans, and you take it to the indigent, and everybody in America in ten years should be walking around with a plastic card which entitles them to services under one health plan or another. The benefits will vary, and so forth, from community to community, employer to employer, and whether you are indigent, elderly, or in the employment status, the

benefits may vary. The benefits will also vary based on your individual choice. If you have chosen to stay healthy, you don't have to buy yourself $200 worth of sick care protection. You can get $75 worth of catastrophic and $125 worth of pensions, or something like that, because you are going to live a lot longer than anybody else. So why buy a whole lot of sick care protection that you don't need because you have committed yourself to stay healthy. Take it from General Mills or Hank_Fuller or whoever -- take it in some other form that you can enjoy rather than wasting it on -- I want to come back to Califano again, but this is very convenient --

(Laughter.)

-- Chrysler -- and he would probably tell you all the great things Chrysler is doing. They are doing a lot of things, but they are still paying Lee Iacocca $1.6 million a year to be President of the company plus giving him $333 a month worth of health insurance that he does not need, and then they are blaming the doctors and the hospitals for the high cost of health care. They are the high cost of health care. If they wouldn't pay Iacocca and Joe and everybody else $333 a month for sick care insurance, they wouldn't have a problem in this country.

So that is the idea. We don't have to have public hospitals. All you have to do is have a choice of a

health plan, and that health plan then has to be able, one, to keep you healthy, two, when they fail to buy the right doctor, the right hospital, the right home health service or whatever.

So government is generally a better purchaser of services than a provider of them. You bet. If government puts its mind to letting people choose their health plans and then just pays part of the premium under Medicare, for example, you could retire from Hinkel and have the same choice in Minneapolis of four or five health plans when you retire. Come in once a year at open enrollment time and make the same choice that you had when you were working. Medicare will pay a part of the premium based on your age, sex, previous health condition, and the average community cost of health care. General Mills, if they want to pay part of the bill, can also pay part of the bill, and you can say the hell with MEDSCAF. You don't need to waste all that money. You can do the same thing with the indigent.

Three, consumer choice is enhanced as information increases. Government policy should facilitate the flow of information. Now, we are talking here about how come the American Dairy Association gets away with advertising all the wonderful health benefits of milk when if you try to do that the FDA puts the screws to you or something like that in your vitamin business.

Consumer choice is enhanced as information increases. Government policy should facilitate the flow of information. Individuals cannot be expected to make sound choices if they are provided with insufficient or inaccurate information. Furthermore, information must be presented in a straightforward and a comparable manner, and I go on to talk about Consumer Reports.

Level playing field, comparable manner. Don't have FTC over here doing this and the FDA over there is doing that and because you come in -- what do you call it -- micronutrient form rather than in a whole damn meal, you know --

(Laughter.)

-- why should you be treated any differently if the judgment has been made that you are in the nutrient business. But information becomes important, and government has to watch what its role is. If government is going to play a role of going down this way because of the shape of the food and going down that way because of, you know, something else, no, that is not what this says. It says information is really information. If choice is going to work, then information has to be there. So I have to know as much as I can about the nutritional value of what you do or what you produce or what Jeno Pizza produces or what somebody else produces, and so if you want a role for

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government, just make sure that if society wants honest information about nutrition make sure the rules are the same for everybody who is going to provide something of nutritional value.

Number four, the price of goods or services should be a true measure of its cost. Government policy should not facilitate hidden costs or cross-subsidies. Wow. You know, you could go on and on and on with that one.

Five, the government should guarantee access to necessary care. However, standards of access cannot be open-ended and must be realistic, and here we talk about geographic access, economic access, a variety of those sort of things.

Six, the responsive market will have fluctuations in capacity. Temporary shifts and increases in capacity are to be expected as markets adjust.

Again, I go back to Joe and Jimmy. You know, they couldn't stand the idea that there were more hospital beds in America than there should be, and they wanted to somehow put those beds out of business. Only the choice was not to let new people get into that business. They said in Minneapolis-St. Paul there is 4000 beds too many, so you can't have any new hospitals. Well, if that is the case, where do I go to get health care? I have to go to the old system. Somebody who has a new product, a new service, or a

new facility can't get on the market under that theory, and if they can't get on the market how will I ever find that I can get a meal in a pill, or whatever your business is, or something like that? Because you can't get to the market. The market has already been taken over by a government, you know, that says we have got too much nutrients on the market, now we are not going to let a more efficient nutrient get on the market. The same thing is true with hospitals and doctors, et cetera.

Seven, the government should establish guidelines for quality but recognize that quality will ultimately be judged by the individual. Boy, that is a tough one. See, everybody wants to know that their doctor is the best in the world, or wherever they are going to get health care.

Well, the reality is marketplace -- in the right circumstances the marketplace will give you a better judge of quality than will the government or somebody else, and I probably take -- it takes probably too long to illustrate that, but the reality is that when it comes to health people do -- would rather stay healthy than be sick despite what I said. That is a mindset that I am talking about. But the reality is people would like to stay healthy if they could, and they are receptive to those who will provide them with the right kind of opportunity to do that.

But government must relax a little and let the

marketplace decide what is quality, and in some cases it will be comfort and convenience and things like that. In other cases it is going to be something more specific, but we have to relax enough through this period of choice and competition to reassess or revalue what quality is.

Yes, we are always going to have licensure and we are always going to have the FDA and things like that. That is important because there are certain technical things that we consumers can't handle, but beyond that the choices about what is good for me really ought to be up to me and not up to the government.

And the last principle is the government's role in stimulating competition should be to assure fair market conditions, not to regulate its particular brand of competition, and that is why I can't get my book out, because we are following that principle. There is so much competition going on, so much choice that I can't keep up with it.

So I am going to stop talking right now and listen to your questions. I would be happy to talk with you about any of this. I would be happy to talk to you about anything else that is going on. I have not addressed tax reform or anything else that you may selfishly be interested -- excuse me --

(Laughter.)

-- be interested in, but I would be glad to do that.

Is somebody prepared with a question?

Yes.

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Piranha Press. I did not select them on the basis of the name. Piranha Press. P-i-r-a-n-h-a. It actually is a fellow who discovered my white papers on national security, a former Marine, and made me write the book after the '82 election. So it is too late to change the name, but that is it. Piranha Press.

Yes.

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Very little.

The question is what percentage of governmental appropriations deal with prevention, and I would -- I can't give you a precise dollar amount, but it is relatively small. I mean, the struggle that we have gone through over maternal and child health block grants and trying to change the statutes relative to Medicaid, trying to get at poor pregnant mothers, who are pregnant particularly for the first time, and to be able to get to them with information about how to use that little built-in neonatal intensive care unit called the womb, you know, and hang onto that baby, you know. We don't -- you know, it is a marvel that

we can deliver at one pound or less than a pound.

(End Side 1, Begin Side 2.)

....society that we do that.

So it is really hard. One of the things right now that is difficult in moving the federal government's appropriation into this process -- and I have got a bill to change the deductible on Part B of Medicare from 75 bucks to 100 bucks but give the elderly credit for a diagnostic, for an examination, for inoculation, immunization, things like that, and I can't move a lot of those sort of things because they "cost" money.

In other words, as you well know, you have got to spend a little money in order to make some money in the prevention business, and the way the budget process works you don't get credit for the saving. You know, you got only the cost to expand the Medicaid program; you don't get credit for moving a newborn from two pounds to five pounds or from five pounds to eight pounds, and those costs, the savings -- and if we could reduce neonatal intensive care beds in this country to the same as they are in Oslo, Norway or Vienna, Austria, places like that, just the same as they are at, we would save billions, billions of dollars in this country. But you don't do it just by spending it on a new kind of hospital. You do it by spending it on mothers. That is how you do it, and it doesn't cost much.

There is a great nun down just south of Tampa, Florida that I met last winter because she happens to be from a little town in Minnesota, and she is at a health clinic down there, and Hillsborough County will pay $550 a day for at least two or three days, I guess, for a mother to come in and have a baby at the public hospital there in Tampa, but they will not pay her $25 a visit for 10 prenatal visits, and she promises them that she wouldn't even have to have the baby in the hospital. I mean, if you gave her 10 visits with one of those -- most of these are -- I guess they are either immigrants or refugees, or whatever women are down at this -- Ruskin is the name of the town in case any of you are from that -- any of that area, but she says I will guarantee you to save the difference between $250 and maybe a little bit at birth and 1500 or $1600 a day. But you can't get through to the county welfare authority to do that. So we are wasting that difference.

That is a good question, but I give you those examples of the difficulty right now in forcing the system to stand on its head and sort of relook things. But that is the governmental side. There are so many other great things going on that you know on the free, and we need -- if we change some of the signals, we would be better off. If you would help us force on the insurance companies in this country lifestyle, actuarially determined premiums, gosh,

that would be terrific. If every time I had to buy a health insurance policy or life insurance policy or anything like that, I could see it lifestyle rated, not just this phony little thing about do you smoke or have you quit smoking cigarettes. I mean something real, something real. It would make a big difference because then you could say to people there are actual financial rewards to you for staying healthy in this system or following the habits that are known to help you avoid accidents or if you wear a seat belt in a car or a helmet on a motorcycle, or whatever the case may be.

So there is a lot of those, as you well know. There is a lot of those, a lot of activities that we as a society using government could engage in that would push this prevention and this wellness that are not direct appropriations of money.

Yes.

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Good for you.

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Well, that is -- what company are you with?

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Are you a little company?

QUESTION: 250 people.

SENATOR DURENBERGER: 250 people. That is really the kind of thing -- did you hear what he said? I mean, that is --

QUESTION: (Inaudible.)

QUESTION: (Inaudible.)

(Laughter and applause.)

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Yes.

QUESTION: (Inaudible.)

SENATOR DURENBERGER: Right. Well, I will invite all of you to send me your experiences in this area and related areas. I would like that very, very much because right now when people ask me about quality in health care and all the problems that we still face in doctors and hospitals, and so forth, and they want to know what is the -- and how are we going to solve this problem, and I say, well, it is up to the employers of this country to solve the problem, and it is amazing to me. I go around to health-based industries like some of your big shot competitors, some of the big name drug companies in this country, and, hell, they are still back to the days where they are offering one self-insured plan and one HMO because they have to in the area and they are doing second surgical opinions and things like that.

I mean, that is missing the point of the

contribution that the employer can make to an employee's health care, as you have just been talking about here, and the role that the employer can play in bringing on to the employment marketplace health plans that are genuine health plans, not -- or call them health insurance, whatever you want, but their principal objective is to keep you healthy, and when you are not healthy -- I mean you don't have to do all this stuff yourself in your company. You ought to be able to have in the community through group health or Aetna or Signa or whoever is out there selling health plans -- they ought to have a plan for you, if you insist on it, that keeps your employees health and, when they are not healthy, that does the diagnosis for you and does the appropriate -- going to the appropriate doctor or hospital.

But most companies when you talk to them about this say, well, we would like to do that but we don't want the hassle. We don't want to hassle our employees.

So it is a -- there is opportunity out there. It is enormous, and every time somebody talks to me about old people live too long and too expensive and all that sort of thing, I really bristle at the notion that my mother should write a living will and should unplug herself and all that sort of stuff because we are wasting -- we, the rest of us who are still healthy, are wasting so much in the way of resources that ought to go to bring young people into life

and those who are handicapped in a variety of ways and to sustain life for the elderly.

We just don't have to do that plug pulling thing because "we don't have enough money to go around." People in this room know there is plenty to go around if you spend it in the right place.

So anybody else? I think I can take one more question if there is one, and then it is 1:30.

(No response.)

SENATOR DURENBERGER: Thank you very much for the opportunity to be here. I appreciate it.

(Applause.)

VOICE: This program is now concluded and has been produced by Audio Transcripts.

Thank you.

(Whereupon, the luncheon speech was concluded.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

COUNCIL ON EMPLOYMENT BENEFITS

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VOICE: Would you please find your seats so we can start the afternoon session. Thank you.

Good afternoon and welcome back.

Senator Durenberger's national prominence is well-known to us all. Within the Senator, his membership on important committees includes Environment and Public Works, Government Affairs, Finance and Select Intelligence, of which he is Chairman. But it is his Chairmanship of the Senate Finance Health Subcommittee and Membership on the Subcommittee with jurisdiction over social security that involves him most directly in national health policy issues.

When we compiled a list of elected official to approach as potential speakers on health topics it was not difficult to get agreement on who we would approach first. Not just because of the committee positions Senator Durenberger holds, but because he is widely regarded as perhaps the most knowledgeable Member of the Senate on health care issues.

We are grateful he accepted our invitation, and I am most pleased to introduce the Republican Senator from Minnesota, David F. Durenberger.

(Applause.)

SENATOR DURENBERGER: I'm pleased to be here. There's a few Minnesotans in the audience. If it weren't for the cost of traveling here, I'm sure there'd be more. The weather here is much nicer in the fall than it is in Minnesota. We have two seasons in Minnesota: Winter and the Fourth of July.

(Laughter.)

No, that's not true, and most of these folks will tell you that. We have the North Stars and the Vikings and now we have Lou Holtz.

(Laughter.)

But Missouri has it all right now, so for those of you from --

(Applause and cheering.)

That's great.

I'm here because I believe in those three lies, the principal one being I'm from the government and I'm here to help.

(Laughter.)

I think you know the other two.

(Laughter.)

But you never practice them, so --

(Laughter.)

But I'm gong to practice the first one and tell you that I am from the government and I am here to help,

including you guys behind the screen over there, and try to be helpful in the relatively brief period of time to peak your curiosity and then to get some questions out of you so that we might learn from each other on the general subject that brought you together.

I spent the morning today not doing what I planned to do, but with an amendment to save a portion of general revenue sharing from being eliminated. It was an interesting first try at Gramm-Rudmann. So those of you who have seen Gramm-Rudmann sort of written about as a way to balance the budget, we had it in practice this morning. That is, I debated the value of revenue sharing and everybody else debated the value of deficits, or the lack of value of deficits, and I happen to win this one by something like 55 to 40, and now that process that will work itself this afternoon.

And if my beeper goes off and he gives me the signal and I disappear from the stage it's not because I was afraid of questions and answers, but because the second half of Gramm-Rudmann, the sequestration process then takes effect and there will be a motion or an amendment by the -- probably the Chairman of the Budget Committee to cut 2.4 percent across the board from all of the programs in the HUD and other -- HUD and the related-Departments' appropriations bill.

And that is in effect what you are going to see here in Washington for the next, well, five years at least. For sure the next three years because that's how long Ronald Reagan will be President and that's how long we will have a substantial deficit because we won't have the ability to raise any money, and therefore you will see nothing --

(Laughter.)

-- already painted himself as a moderate, right?

(Laughter.)

So what you will see if a series, a spring series, a summer series and a fall series. Sort of like the Stanley Cup playoffs of -- whatever it is in the summer and the World Series in the fall all around budget issues, and it will be do you -- you know, how much are you going to cut the deficit and what are you going to nick to do it. And the reason I may -- I don't want to sound like I'm making light of the process. I am alerting you to a dangerous process that this country is going to go through for the next five years, and that is the assumption that some how you can balance the budget and still not live within your means by just cutting spending.

Now, I have never believed -- unfortunately for some of my constituents, maybe. I have never believed that you could balance the budget simply by cutting spending and cutting taxes. At least not the federal budget. A third of

the federal budget is social insurance programs, and you all discussed all morning long retirement programs and all that sort of thing.

Well, a third of the federal budget is our sponsored income security programs, and they are driven by nothing other than the number of people that qualify and the cost of living as against the set of benefits that we have provided for them. They've gone up from $199 billion to $322 billion while Ronald Reagan was preaching balancing the budget.

Another third of our budget is committed to our national security, and that one has gone up from $145 billion to this year, $302 billion while Ronald Reagan was busy balancing the budget.

And there's a third one, which used to be a small part of our budget and today is 15 percent of the budget, which has gone up from $49 billion in Jimmy Carter's last year to $175 billion gross and $137 billion net this year, and that is, debt service. Interest on the national debt.

Now, those are annual figures. You add all of those together, subtract them from the total federal spending, $967 billion in the current budget resolution, and you have a measly $190 or $195 billion in other spending to be cut in order to balance the budget which is $210 billion in deficits.

So, tell me how you are going to do that? They aren't going to do it by cutting spending or tax it. We have cut a lot of spending or raising taxes. We've cut a lot of spending, but all of it under the pressure of low revenue. We cut taxes by 25 percent, brought the marginal rate down to 50 percent, got IRA's and 401-K's and pray that we hang on to them, and all that sort of thing in 1981, and we made sure that the income tax would not exceed the level it was at in 1981 and it hasn't. So we did it right. We went four years without raising any taxes, which was our objective. At least one of our objectives.

Today the individual income tax raises $331 billion out of a $967 billion spending requirement. So if you want to use income as a basis for taxation because it's the fairest place to go to get taxes, you're not doing a very good job. You're only collecting one-third of what you need.

Now, you might say, well, go to corporations. Good place. You combine talent and money and people, labor and things like that and they make -- they sell goods and services, make a profit. Let's tax that profit in some way. Well, you know that one hasn't been used very much in America, other than as a way not to pay taxes.

This year the corporate income tax will raise -- contribute to this total problem $58 billion. Now, the last

time -- well, it also raised $58 billion in 1977, for example. It's a nothing. Last year it raised $36 billion. Corporate income tax is nothing, particularly to big companies. It takes taxes from small companies, but it doesn't do much for big companies other than keeps your law department and your tax department very busy.

(Laughter.)

So there you are. You've not got it up -- you haven't even gotten $400 billion. Well, the deficit is not $567 or $577 billion. No, of course not. Why not? Because we have judiciously put in place a little something that nobody seems to notice unless -- except I found out lately that the folks under 35 or so noticed it. Thank God for them -- called the payroll tax. It's called a tax on going to work, and everyone of you know about it because the price of going to work in America today for every person each year is today $5,400. And that's just going in. That's just to take care of social security with its disability and Medicare component. On top of that you pile unemployment comp and then on top of that, if you can reach that high, you put workers' comp.

Now, that's the price of going to work. In four years that's going to be $8,000.

But who is complaining about it? I haven't heard Ronald Reagan complain about it. I haven't heard any of you

people complain about it. I don't have a single letter in my mail room from any of you alerting me to the danger of an America which is going to try to balance its future on the backs of work. You should be alarmed at $8,000 because you've got to start on top of that to give away health insurance and life insurance and day care and, you know, pretty soon, you know, it's $12,000 just to walk in the front door before you got any -- you give them any cash.

You promised them retirement, which you can't deliver for them -- at least not those under 35 in social security -- and you promised them unemployment comp in a fund which in many states, like ours in Minnesota, is broke and you promised them workers' comp in a sort of a competitive environment across this country in which we waste more money than we actually put in the hands of people for compensable injuries. You've got a hell of a job convincing that you have forked out $12,000 before they get their first dollar for working. But that's where we go. This year $325 billion will be added to the total revenues off of the tax on work.

But on that one, ladies and gentlemen, we are about -- maybe in the next ten years some place -- to face a revolution from my children's generation. I know that because I started a little organization called Americans for Generational Equity. The acronym is AGE, A-G-E. Sooner or

later you're all going to be asked to join. And I started it because, believe it or not, I was born in 1934. I bet you find that hard to believe.

(Laughter.)

But I was. My parents had me when I was all they could afford to have, and they swore when they came to political power with the Hubert Humphreys and so forth after the second world war, I would never have to live through what they lived through and they made good on their promise. They created what, having without paying for it. That's what they created, and I have had 30 glorious, wonderful years of having without paying for it.

(Laughter.)

And I am now about to be the first generation in at least American recorded history to violate Tom Jefferson's moral principle. That it behooves everyone and it places a responsibility to leave the next generation at least as well off as my own. My kids are the first downwardly mobile generation, and you all know it --

(Laughter.)

-- because you see what those young people are taking home.

On the other hand, my having, for example in housing, has priced them out of some markets. My parents bought their homes in about five annual installments or they

didn't get them. They rented from somebody else.

But I have only spent -- my whole adult lifetime, I have spent only $500 on housing. A total of $500 and that was that first 1959 or 1960 $500. That's all I've ever spent because there was a promise to me from my parents' generation that I could have housing without paying for it. So they said $500 down is the going in price. The other $10,000, you know, you can write off over 30 years with tax deductible interest and so forth.

And everybody in the country my age stood up -- and even some older folks -- and waved their $500 bill, and there were twice as many people with $500 bills as there were homes. So what happened? The price of homes doubled, right? Isn't that what happens when you've got an excess of demand over supply? The carpenters who were working for $2 an hour building the homes, when they saw such a demand, charged $4 an hour and then $6 and then $8 an hour.

My last home I bought in 1972 in the lake area, the south side of Lake -- in Minneapolis. I paid $77,000 for it in 1972; sold it in 1978 for $245,000. One coat of paint.

(Laughter.)

But folks, we laugh, but we've had it, haven't we. We really have had it. We have gotten the price of -- average price of housing now up nationwide $86,000. My kids

can't -- haven't got $86,000, particularly at the going-in price of housing. I mean, the entry level and the income requirement to pay that off. 93 percent of these young people in American don't have the price of a home, unless we subsidize it. Unless we subsidize the builder to build the housing for them or we subsidize the interest rate with a real estate tax deduction or subsidize something, they can't afford housing.

Health care is the same way. That's what we're supposed to talk about this afternoon, I guess.

(Laughter.)

Same thing. I read the little article and I didn't prove it -- oh, the hell with these notes.

(Laughter.)

I didn't prove it and so I didn't want to pick on General Motors, if they're here today, really not, but I saw a little note that GM got out a report and so forth on health care. And I, like Walt McClure who is also quoted in that article, I applaud GM and Chrysler and Ford and all those people who have it really tough running up against that union, as Chrysler is finding out. It's really tough to do anything in health care, but they're doing a whale of a job.

But in that article it said that Roger Smith and Beaver appeared on the same platform, and what did was

condemn the fee-for-service system in America as being at fault. That's why we've got all these problems. It's those doctors and those hospitals and the way Blue Cross and all those folks pay for insurance.

I'm willing to admit that's part of the problem. But let me tell you, folks, that system was not created by Blue Cross or by the American Medical Association or by the American Hospital Association. It was created by the people in this room. You and I. We created it with the best of intentions. The same intentions my parents had when they created having without paying for it.

It was much cheaper to society to buy health care at the work place. You have a group of people who could share the risk of providing health care. It made perfect good sense. I don't know which one of you was first. Either Sears or Monkey Wards, I think, was the first one in 1904. That's what I got from reading the book.

(Laughter.)

Shows you how smart I am.

That's where it started and then it caught on. Long before Bob Packwood it caught on.

(Laughter.)

Because it was a good thing. It really was a good thing.

In 1954 some of your predecessors said if it's

such a good thing, let's tell the politicians about it. So they told the politicians about it and when they revised the 1954 Tax Code they said let us bless, with government's blessing, this arrangement between employer and employees. Let's make sure we get a business deduction for the premiums and the employees do not pay income tax on the value of that premium -- or on the dollar amount of that premium.

From then on the United Auto Workers or the steel workers or whoever you happen to ask, or you. My employer, the former governor of Minnesota, great guy, didn't have a union, he was just the guy who believed in doing things for his employees that they wouldn't do for themselves. And people like that said they won't buy health insurance if you give them cash. They won't buy life insurance if you give them cash. You can't trust those people to take care of themselves. They won't do it. So we will do it for them.

I went to work for H.B. Fuller Company in 1971 and I had everything free. I was your Mister First-Dollar Coverage. I was just one of 10,000 employees or 6,000 employees in the company at that time who paid for nothing. My pension was free; my health insurance was free. Everything was free. And we used to just praise Elmer, the Chairman of the Board. Wonderful guy. Did all these wonderful things for us.

Yeah, you know what Elmer did for us? What all

of you did for us, what we all did for each other? We created having without paying for it. YOu can have two and a half packs of cigarettes a day for 25 years, like Dr. Barney Park had, and society will come along and give you an artificial heart. You can ride a motorcycle without a helmet and a car without a seat belt, small yourself to smithereens and somebody else will take care of you. You can go to a hospital any day of the week or anytime you feel like it -- you got an ache and pain -- and stay there as long as you want and somebody else will pay for it. And on top of that, your employer will pay you to go to the hospital and your fellow employees will show up with flowers and cards to tell you how wonderful you are.

(Laughter.)

So what happens if you stay at work? They make you work. Nobody sends you cards and flowers.

(Laughter.)

Nobody says thank you for staying healthy.

Well, who is at fault? Who is at fault? Well, you know, we're all -- we're all at fault. When they blame the docs and the third party reimbursement system and cost base reimbursement that's true. But it wouldn't have been like that if it hadn't been for Roger Smith's predecessor and Beaver's predecessor getting together and deciding that as long as the government has blessed this thing with a tax

subsidy, let's give it away.

So there we are. That's what you and I -- me for Medicare and Medicaid and you for everything else in this country -- are trying to wrestle with right now, and I couldn't say what I'm now going to say to you about three or four years ago, but I think you're doing a fantastic job. I really think you do, particularly the people in this room, because none of you were trained to take this job up. You were trained more for doing the pension stuff and Lord knows what else, or maybe you were trained to do something else and you got moved into this because all of a sudden it became a crisis and it needed a special kind of a talent or something like that.

Very few of you were trained as health policy experts. I was not, that's for sure. I had to learn the hard way to be an expert on health policies. But it wasn't all that hard. Once I got it through my head that I didn't have to make decisions for all those Medicare people -- they could make better decisions for themselves than I could make for them, once I got that through my head I was home free because I bought into consumer choice and health care. And I agreed that when 3-M and Honeywell provide the half a dozen choices or a dozen choices of health plans and they make sure those health plans have to compete with each other on an equal playing field, the whole community turns around.

The hospitals get down on their knees and the doctors get down on their knees, or some of them go off and do something else, other than doctoring, because people will take advantage of choices if properly presented and properly financed. They'll take advantage of those choices.

And we presumed for so many years -- I mean, when I went to H.B. Fuller Company, here was my health insurance. I didn't understand the damn things, you know. I put it in a box someplace and every time I got a bill from my doctor I gave it to my secretary and she processed it, and I wondered why it took six weeks to process and I complained about the system.

(Laughter.)

No wonder people assumed I couldn't make choices, until in the Minneapolis-St. Paul area they pioneered choice. Well, they didn't pioneer it. The Federal Employees Health Benefit Plan really pioneered it. Now I have 22 choices as a federal employee. The government's done a very poor job of laying those choices out for me until just recently. We've learned a lot from business on how to describe those choices and how to make the comparison.

Once I learned that was the key to it, I said that's the way Medicare's got to go, and then I also said that's the way Medicaid's got to go. Then I said to myself

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there's no reason in the world why five or ten years from now the whole country can't be buying private health plans from a choice of health plans. You don't have to buy doctors and hospitals. Buy a health plan and let those folks buy your doctors and the hospital for you. Or, better than buying a doctor and a hospital, buy something less expensive and equally as efficient.

But you can only do that -- you can't go into the business of doctor assessing and ambulatory surgery assessing and that sort of thing. But you sure can get into the business of health plan assessing. And the ones that don't meet up to your satisfaction for quality and everything else, don't let them come in next year. You've got to be in the business of making sure the right kind of health plans in each community are the ones that are offered to your employees. Don't try to leap over that and become an expert on doctor bashing and hospital bashing and all that sort of thing, unless you're the only act in town like R. J. Reynolds might be in some communities.

In fact, that happened when I was in Winston-Salem.

Is that where you're from?

VOICE: Yep.

SENATOR DURENBERGER: Okay. That's a whole other story and I don't want to embarrass myself by telling it.

(Laughter.)

So -- but it can happen for everybody. Vouchers, whatever you want to call them. They're the things you do. You lay out all these choices for people and say I'm going to put $200 in each of those choices, or $195 or $250, whatever it may be. At Chrysler I guess it's $300 or something like that. That's like a voucher.

You do the same thing for Medicare, and that's where we're going with competitive medical plans. Instead of our being in the DRG business and all the rest of that stuff we're in now, we will be in the business as quickly as possible of financing a part of the premium choices of the elderly and the disabled. So they will buy from the choice of health plan that in our community are marketed like mad. Same choice. Probably the ideal thing is when somebody retires from R. J. Reynolds, they have the same choice -- if they stay in Winston-Salem or Washington, D.C., they have the same six health plans to choose from, and if they want to continue with the one they had the last 15-20 years, keep right on with it.

Then what you can do -- I take my dollars, my Medicare dollars and I actuarially compute out an amount for that individual: age, sex, previous health condition and average community cost of health care. So each dollar will differ somewhat. I put my money in the pot. If you want to

sweeten the pot with part of your retirement program you can do that. Right now you're all scared to death -- well, not all of you maybe, but a lot of you are scared to death of that unfunded liability out there for providing health care to senior citizens.

But we can alleviate a lot of that if we all get into this one together. I'll pay my part of it and you add something on for yourself. Let them have something for themselves (inaudible) and that's it, period. No medicap, no supplemental, no every time a Hollywood actor reaches age 65 does he get to go on television and rip people off --

(Laughter.)

-- down in Florida now, nine months out of the year, and complain because their bills aren't being paid. Well, their bills are postponed, except the bills from the medicap. It costs $76 for each of them per month to buy and to wrap around their Medicare. They're wasting $1,200-$1,300 a year. They don't have to do that. If I would put catastrophic into Medicare and then you would add and everyone would add for them as employers, that's all they'd have to do. Continue the same choice for the rest of their life.

And you do the same thing for the indigent. Don't have to (inaudible) in public hospitals in this country if the politicians will step up to bat and agree to

finance a choice of health plans for the indigent. It may not be the same benefits everybody else gets, but just finance their access to the health system. These plans and these doctors and these hospitals will need that business. They'll need that business. They use a lot of business in our household, right, John? We're down to 47 percent occupancy in the Twin Cities. They refuse to close them.

So, they need the business. They don't want it all to go to the public hospitals. They could all use that business and the only way they can all use that -- get that business is to bring the prices down and improve their quality so they meet the standards -- same standards of health care as the elderly would demand and employed population would demand.

I think that is the direction that this country needs to have. And again, in a general sense, adding in the modifications as we go along is much easier said than done. Medicare patients have already indicated to you we need to put catastrophic in there, so they quit buying all the rest of that. We need to put preventive health benefits into those plans. We put them in and that's the way it ought to be.

Then we need to means test the Medicare program. There is no reason why Medicare should continue to be an entitlement. It can be (inaudible).

Then we all need to figure out a way to add that sort of social insurance component to the Medicare program so that not only do people have acute care, but they have access to the -- in an insured way -- to the kinds of social services that keep people healthy and keep them out of hospitals and away from doctors. Only 3 percent of the people in this country now are in some kind of an insured social insurance program. We desperately need to add that kind component. Well, those sort of things in the Medicare sense -- get all the elderly out of Medicaid and put them into Medicare. Those things need to be done.

On the employment side, don't mandate benefits. Tell the states they shouldn't mandate benefits. To do all that between you and your employees. You'd have much better quality in deciding on chemical dependency benefits or mental health benefits or dentistry benefits or whatever than if the state government in Minnesota or the federal government in Washington, D.C. You make whatever arrangements in terms of benefits and don't let us mandate those benefits, other than catastrophic. I would like to mandate catastrophic and choice -- require you to get the choice in there -- and also continuity, which we are in the process of mandating right now.

But those three are really the only things that ought to be part of the mandate.

As far as the cap on the fringe -- on the benefits are concerned -- I've told most of you this before -- I do not believe that the Packwood tax would bottom. I don't think anybody else does any more either. But you all know where I stand on the (inaudible). I believe it strongly, but I'm not going to break (inaudible). Want to continue to put more and more money into Lee Iacoca's health plan you go right ahead and do it. You're just adding to the deficit and I'll try to look the other way as long as I can without getting a little angry that my farmers in Minnesota and those people can't afford any health insurance. If we can get $300 a month subsidized by the taxpayers and a self-employed person get's zip.

I've got a bill in to rectify that. We're going to -- (end side one)

And that -- a million things I have to talk about in health care, but I know I've talked much too long. I thought I would keep it at the larger level and let you get me more specific. I appreciate all of your being here and I really do appreciate your patience with Washington, and I am grateful to somebody whose spent a large part of his public life to changing the health care system.

I want you to know that you're doing it, not Margaret Heckle, with all due respect to Margaret and Ronald Reagan who are certainly contributing by their support for

the prospect of reimbursement in this country. The genius -- the genesis really for getting this whole thing turned around is the folks in this room, and I just congratulate you for what you've done.

Thank you very much.

(Applause.)

VOICE: Thank you very much.

Fortunately, we do have time for questions and would appreciate it if you would pass them to the aisles so that the Trustees can bring them up.

VOICE: We have a Democratic organization.

VOICE: To speed your questions.

(Laughter.)

SENATOR DURENBERGER: What are the chances of mandating well-child care. It would make sense to start preventive care --

Well, it makes perfectly good sense to get that kind of benefit. To ask me to mandate it, you got my position on mandate. I just really think that if everybody believes preventive care is worth-while and I don't know why you'd argue it, that you wouldn't put it in there. Now, the problem will be that folks don't want to give up the acute care stuff in order to get this, and if you proposition it as having to give up something else in order to get this then you come to the government and insist on a mandate.

I just don't think we can or should be responsive any more to the requests for a mandate -- for mandating. So, should it be there, yes. I'm trying to get it into Medicare -- Medicare right now. That's obviously a negotiation that takes place in the budget process and with the elderly to get it in there. But it's very, very important that -- what we do on Medicare on my bill is to qualify preventive care like diagnostic and immunization and so forth as part of the deductible. We increase the deductible, then qualify those preventive services as covered under the deductible.

So, it ought to be there, but don't look to me for mandating.

VOICE: Okay, Senator, I'll read the next one.

There is currently a bill being considered to require continuation of medical coverage for widows and divorced spouses. How much longer can business be expected to take on additional costs and remain competitive in the business world?

SENATOR DURENBERGER: Probably for as long as you're in business, and that's not -- that is not really a flip answer. It is just a reality that you can buy those benefits, the health care benefits, a lot more cheaply than we can or anybody else can. So the decision we made relative to continuity is to have you make the buy on behalf

of the widows or the divorcees or the children that reach 18 or whatever it is, and I know it isn't going to be easy going in. You've got to keep track of those people for 18 months or something like that in order to make sure that we can meet that need.

But it is, from a societal standpoint, an exchange again for a $49 billion -- currently a $49 billion a year subsidy for what you're doing for employed people and in appreciation of the fact that you will have to spread that in some cases over a narrow base. We are on the track of continuity and at this point it can't be derailed. The thing is to keep the period as short as possible.

I recommended only one year and I still think that is plenty of time. But the proposal that we have in there now is a -- the Senate side is 18 months; the House side is five years, and we in effect blended the people who qualify and now everybody in effect qualifies, and I would imagine we'd be settling around the 18 month period of time unless somebody can talk us back down to one year.

I think the provision on payment, the cost that will carry, will be the one from the House side -- or the Senate side, which is that we will charge those people 102 percent of the group rate to participate in the plan. But that is -- so, in effect, in the rate side or the premium side there's no cost requirement. But I have to recognize

that, yes, it does cost you something just to keep track of those people.

But the reason, again, is that's the best way to make sure that some indigents in America and some disadvantaged people in America do have access to health --

VOICE: Senator, how soon do you see a resolution of the cafeteria 125 benefits issue?

SENATOR DURENBERGER: I don't know. Each time I make these speeches I answer that with a date and I'm not going to do that any more. I don't think there will be a tax bill this year. I don't know if there will be a tax bill next year. I'm afraid the next tax bill that comes up will just be a -- will be a -- one of those minimum tax kind of bills that doesn't make a lot of sense.

So, I really cannot predict when we resolve that question. The best place to resolve it is in the context of fringe benefits taxation. I don't think we'll get into the larger context of fringe benefit taxation in the near term because that will get done in the context of over all tax reform.

If Ronald Reagan wants to get rid of 401-K's can you imagine what he's doing to do with the cafeteria plan, and so I'd rather not have that kind of tax reform because it doesn't make any -- it just doesn't make any sense. It's a loop hole-closing kind of tax reform.

Now, I can pledge to you that those of us who believe in straightening out the cafeteria plan issue will do it on the first available vehicle. By the same token, we'd like to get something for our commitment to do that and my price has usually been the tax cap. Most of you aren't willing to settle.

(Laughter.)

VOICE: Senator, some businessmen resent the HMO's for not sharing their economies of operation with employers. What do you think?

SENATOR DURENBERGER: Well, I'll have to tell you what I think and not what I know because this could sound to some quite critical to some of my colleagues that are in this room. They can answer it better than I because the only time I get a sort of a close first-hand experience is looking at my home in the Twin Cities.

My impression is that you can get -- in a competitive market like we have in the Twin Cities you -- there's no reason why you can't get them to share that benefit. It's all in the way you are willing to -- what requirements you lay on those plans in order to get into your market. And if you admit a bunch of HMO's into your group and pay them the highest premium that you paid the last plan that was in there, or something like that, all you're doing is saying they can charge you anything up to

that amount.

So, if you've got that amount (inaudible) too high, hell, they can all get in under that and make money. And I think in some case in the Twin Cities that's what's happened. Sometimes this happens because of unions and Lord knows what else.

But I can't think of a good reason why you can't operate that just like (inaudible) and if you make equal contributions to everybody across the board, you keep that contribution low enough, you're going to force those people to share the economies with the --

VOICE: Could you comment on proposed non-discrimination coverage test of Treasury 2?

(Laughter.)

SENATOR DURENBERGER: Is that in --

VOICE: The President's proposal to have a common uniform test against discrimination --

SENATOR DURENBERGER: Somebody is going to have to clarify that one for me. I recall that that --

Who asked the question?

VOICE: It's just dealing with uniform coverage. In other words, providing the same level of benefits to all employees, including part-time.

SENATOR DURENBERGER: No. You shouldn't have to do that.

VOICE: Okay.

SENATOR DURENBERGER: No, you should not have to give the same benefits, other than if you've got the same people in the same -- but people ought to be able to choose more or less or whatever. You've got to have the same package of benefits up there for people to make comparisons to, but they can take more or less of that or whatever and it ought to be measured on the net result of consumer choice and not say that everybody has to get the same set of benefits.

Also, there ought to be no reason why you couldn't in different markets put out a different product as well. It just may be appropriate to certain parts of the country where you have certain kinds of workers. You have an older work force or whatever. There ought to be reasons why maybe in certain market you put out a different set of benefits. But you still have to be able to have some choice, but in that -- employee choices within that --

VOICE: What do you mean by a means test for Medicare? Could you expand on that?

SENATOR DURENBERGER: Yes. The proposal that I put forward a couple of years ago would lower the Part B premium to either -- I think it was 15 percent of program costs. Today it's 25 percent of program costs. That would make sure that the so-called really poor people could afford

to buy Part B.

Then I got the money back by charging 1 percent of adjusted gross income on everybody's income tax, and that in effect got all of the money back for the program costs and only half of the Medicare eligible actually paid anything back in. So everybody got a reduction in their premium and only half the people have to pay something, as 1 percent of adjusted gross income.

Now, when we blend B and A, which we eventually will do so it will look like everybody's insurance plan. Rather than having a separate hospital and separate doctor, we blend them. When we do that, then of course we will maintain the premium. We won't up front and, again, means test that premium off of people's income tax. Now that is one way to do it. That's the only way that I have found so far that will accomplish it. It will mean that anybody who wants to get their money back will have to file -- everybody in effect will have to file an income tax return. That's my version of --

VOICE: I think we have time for one more question.

SENATOR DURENBERGER: Okay.

VOICE: Choice is fine, competition is fine. But if you give up DRG's prospective payment system won't -- providers will lose their incentives to control costs.

Please comment on this.

SENATOR DURENBERGER: Thank you for that question.

We will only give up DRG's in a market where we know differently -- if prospectively priced health plan replacement exists, so that when John tells us that the Twin Cities market is -- the health plans there are all prospectively pricing -- are insisting on prospective prices with the hospitals and the doctors. They might be on per diem or something else, other than DRC's. But when he and everybody else in the Twin Cities tell us that community has got -- all their plans are buying on a prospective basis then it is easy for us to get out. They could use -- the plans could use DRG's or something else.

But prospective pricing really is here to stay and we won't -- obviously we won't go out of the DRG business until the last community in the country. This will go community by community. The last community in the country has in effect converted to a CMD plan in which the plans (inaudible).

I don't -- I cannot see the day that we would go back to health (inaudible). The doctors like it better. They complain. Everybody is complain. Well, you know, how many really bright hospital administrators have you discovered lately that you didn't know were really that

bright. How many of them would you like to have working in your company. I mean, some of those folks are pretty sharp. But we didn't know that until we gave them a chance to run their hospital like a business, and I think that kind of creativity has been -- we've been waiting for that. Professionals have been waiting for the opportunity.

So, I don't think it's going to -- it is going to change, unless somehow the politician changes by not dealing with some of the subsidies. This is --

I need to congratulate a lot of you on your commitment to indigent care and trying to us -- everybody who is not indigent. One thing that could sort of tip this over is that we don't deal with the now-exposed subsidies in the hospital business or indigent care. We have to find a way to do that. Various states are doing it in various ways. My favorite way is to make the politician face up to it and pay for it.

I must acknowledge that I -- there is a federal obligation, state obligation and local obligation. We need to come up with the dollars to cover that and not keep that in the hospital system.

Thank you. I'll take the rest of the questions with me and --

(Laughter.)

If there's no name on it, you're in trouble.

VOICE: No, we don't have any questions at the moment because I know you have to go.

If you allow me to quote a fondly-remembered Democratic Senator from Minnesota, Senator Durenberger, we're pleased as punch --

(Laughter.)

(Applause.)

TRANSCRIPT OF PROCEEDINGS

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Featured Address:

Senator David Durenberger, (R-MN)

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EX. 220

VOICE: This is Tape No. 13, with featured speaker, Senator David Durenberger, recorded live in New Orleans on Friday, March the 8th, 1985, at the 1985 annual meeting of the Federation of American Hospitals.)

THE MODERATOR: Gentlemen, we will continue with our program for the day. I hope you had a good visit to the exhibition area and had a "Po Boy" lunch and are now ready for some additional edification. We have got a real edifier.

It is a pleasure to welcome all of you to this additional session in the afternoon. I think you would agree with me that we had two outstanding speakers earlier today. I have heard a substantial number of compliments on the presentations by Dr. Greenspan and Undersecretary Baker. Your participation was excellent, and we appreciate that very much.

Now, this afternoon we are in for another treatment -- excuse me, I mean "treat."

(Laughter.)

And I sincerely mean that.

The only begrudging attitude I have had about this whole meeting is that Mike Bromberg preempted me in

introducing our next speaker because I would have liked to have had the very high personal privilege of doing that myself.

However, I do take pleasure now in introducing to you Mike Bromberg, who will in turn introduce this distinguished man, but before I do so let me express --

(Laughter.)

Easy, Mike. You are too eager. That is your trouble, Mike.

Before I do I want to express my personal appreciation again and that of all the membership of the Federation to Mike Bromberg and to his hard-working and dedicated staff, the Washington staff and of course the Little Rock, Arkansas staff as well. The work that has been done in preparation for this meeting has been difficult at times, trying on occasion, but certainly carried out in a manner that is typical of the way this group operates. We appreciate what you have done in this meeting, Mike, but we look back over the years and thank you for an organization which has grown to be a nation -- this nation's premier health trade association in the area of health legislation and regulation.

Mike's leadership, his rapport with both the Congress and members of the Executive Branch of government have given our Federation a strong voice -- therefore, you

and I have had a strong voice -- in the direction of health policy in this country. We do appreciate that, and we try to recognize it on appropriate occasions.

Now I present to you Michael Bromberg, the Executive Director of the Federation of American Hospitals.

(Applause.)

MR. BROMBERG: The reason I preempted him is so I could do what I am going to do next, which is ask all of you to give Winfield Dunn on his last day as President of the Federation of American Hospitals a big round of applause for one year of very hard work and good leadership.

(Applause.)

In introducing Senator Durenberger, I was given pages filled with biographical material, but I think I want to concentrate on a few things that are semi-personal, the first one of which is to say that it is really a pleasure to see a politician up here with a couple of sheets of yellow paper instead of a prepared text because that is an indication that you are about to hear someone who tells the truth and who is going to think out loud and who is not just reading a text, but also that he is someone who really cares about issues, including health.

He is one of a handful of people in the Congress who really can afford to spend the time to study health care and is determined to do so and learn a rather complex field.

As the budget process unravels over the last few years and in the future years, power seems to become more and more concentrated into the hands of a few members of the House and Senate who are willing to take that kind of time, and Senator Durenberger is one of them. He is obviously a leader in the legislative area in our field. He is a person who just was reelected to the Senate in Minnesota a couple of years ago against an opponent who spent $7 million, and Dave managed to pull that off, and it has been 30 years since a Republican was reelected to the Senate from his state, in Minnesota.

He graduated the law school in Minnesota and became Chief of Staff to the Governor. He has had extensive experience in business, and by the time he ran for the Senate he had served as Chairman, President, or Vice Chairman of more than 15 major state, regional, or community commissions and organizations, a man who is dedicated to public service.

He is one of the few members of the U.S. Senate ever to serve on five committees. He is going to chair Intelligence as well as having served on Finance, Government Affairs, Environment and Public Works, and Ethics, and he is certainly a leader in our industry.

Now, in conclusion, I just want to quote someone who hasn't been quoted yet. The Undersecretary this morning

quoted everybody I have ever heard quoted, ranging from Yogi Berra to Shakespeare, and I am going to do something I have never done. I am going to quote my wife, who is very perceptive and who has to come with me to a lot of political events, and she is from the Plains, Midwest or the Plains, the Dakotas, and she has always been telling me that people are different out there. They are not like Easterners that run politics in Washington, and when she met Senator Durenberger for the first time she said something that I am going to quote. She said:

"He's a real person."

And with that, I want to introduce Senator David Durenberger, a real person.

(Applause.)

SENATOR DURENBERGER: Thank you all very much. That is very nice.

Marliss, I thank you. Somebody get her a seat. She went shopping.

(Laughter.)

I love to hear all those committees of which I am a member rolled off, particularly when they get to Intelligence and Ethics, because everybody wonders what that has to do with being a Senator.

(Laughter.)

And I want you to know, Governor, former

President, former Governor, former President, that I am not an edifier. I am a Catholic.

(Laughter.)

Sometimes. I am also a Republican sometimes.

Washington, D.C. is often referred to an island of ignorance surrounded by reality, and that is why you have your meetings out here in the boonies, and to prove it --

(Laughter.)

-- I am going to speak to you. Right. No, I am going to show you something you missed today, and that is the Washington Post -- and I don't know how some of you can live without it. I know Mike's staff can't live without it. And then I am going to show you the Times Picayune.

Now, the Times Picayune may not be the greatest newspaper in the country, but it is a typical, small town newspaper, I guess, and the headline here is "Utility Buyout Agency Created," followed by "Jailed Rapist Free To Roam The Streets During The Day." I bet that is good for conventions.

(Laughter.)

Where are the women? Where are your wives?

Okay, sorry about that.

"78-Year-Old Pulled Feet First From Car Submersion."

Then there is something called "Edwards Rebuffed

In Poll." I have no idea what that means.

(Laughter.)

"Police Dog Wounded In Line Of Duty." Isn't that terrific?

Way down on the bottom it says "Budget Panel Stalled On Social Security Plan."

(Laughter.)

Now, now in the real world out there, outside the Times Picayune. In the real world represented by the Washington Post this is what the Washington Post looks like today.

"Senate Budget Panel" -- right away you know it is the Senate Budget Panel, not just whatever that said, "Budget Panel Stalled" -- "The Senate Budget Panel Reaches Stalemate Over Social Security." You know, that is the big news in Washington.

Over here, "Schultz Intervenes On Loan. Inter-American Bank Is Asked To Defer Funds For Nicaragua."

Down here, "Military Response Plan To Star Wars."

How about "Tucson Patient Given New Heart"? I bet that got discussed around here today.

Or "Chrysler Cuts U.S. Plans." I am going to talk about that later.

Then here is a great one if you can -- I don't know if you can all see this.

(Laughter.)

This is a picture. It is a guy asleep on a tennis court, right? Can you see that? There he is sitting there. He has got his shorts and his tennis shoes and everything on. Only he has got this cloth over his head that says "Farabundo Marti," and under here it says "Salvadorean Army Spokesman Killed By Gunmen In Capital," and this is Colonel Cienfuegas between sets. He got a bullet through his head.

(Laughter.)

So I checked the story, and, you know, apparently it happened about noon. So let that be a lesson to those of you who take off in the middle of the day to play tennis. You will make the front page of the Washington Post.

Also, there is a great story inside there about coffee. I don't know if that appeared in the Picayune, but coffee is now verboten for those of us who don't want cholesterol. I guess everybody does not like cholesterol except Humana.

(Laughter.)

Nobody cares about coffee except the Sandinistas and the Freedom Fighters, and speaking of Freedom Fighters, I want all of you freedom -- freedom for the for-profit fighters to be sure that before you leave here you all write out your PAC checks and you drop them in the Henson Moore

for United States Senate booth, which I am setting up right outside in the hall, and I will have it set up before he gets here so you can all pile your checks up there before he comes and speaks to you tomorrow.

But it looks to me like he is a good bet to represent the State of Louisiana in the United States Senate. More than that, I am sure he is going to represent in a larger sense the kind of interest that everybody in this room I know cares about, and he is going to prove that tomorrow. But like Minnesota, this is a Democratic state.

I will never forget when I got elected to the Senate and made it on the Finance Committee I got a letter from Russell Long, and Russell Long, Chairman of the Finance Committee, wrote me this terrific letter about how all the way back to 1803 Minnesota and Louisiana have had this wonderful tradition of cooperation. Well, anyway he was replaced two years later by Bob Dole, as you know, and it wasn't because I didn't cooperate with Russell Long. Everybody cooperates with Russell Long in the United States Senate.

But Henson is going to be the next Senator from this state, and I sure would recommend that all of you get on board early. It seems like his most likely opponents on the Democratic side are also experts in health care, but they are all under indictment.

(Laughter.)

President Reagan called me yesterday and sounded like he intended to speak at your next year's meeting. Not good news to you maybe, but it is to Henry because he is going to be President. The last thing he said to me was see you in Managua.

(Laughter.)

And I said over my dead body, and this morning I heard Bill Casey was checking to see whether I played tennis or not.

(Laughter.)

Last week I was in Dallas, and I had to think of a Texas story to tell in Dallas, and so I came across a very brief one. It turns out to be sort of apropos and it is a way to get into what I want to talk about today, which has a little bit to do with what is up in the upper righthand corner, and maybe if I tilt this up a little bit -- I really shouldn't mess around with microphones, but -- all right.

The question is asked by pecple from outside Texas why were there so many heroes at the Alamo, and the answer, obviously from somebody who is also not from Texas, is because there was no back door.

(Laughter.)

Well, Washington, D.C. is getting very close to the point where there ain't no back doors. There is very

little way to gracefully get around the reality that the future of the country and the future of the world rests in some way on decisions to be taken somewhere inside that ring of reality on the Potomac.

Part of the reality is that there is a back door, and periodically by 13 to 9 and other kind of votes people try to crawl out the back door. But in a political sense the Democrats are standing by that back door, not willing to let the Republicans out the door, trying to keep us in the Alamo to take on the issues on which we won the election.

I know everybody in this room knows that except for 3170 people in Minnesota Ronald Reagan was elected President of the United States by everybody in this country. It was a landslide election. He had the biggest electoral mandate in the history of this country. So the Democrats are standing by the back door making darn sure that no Republican sneaks out the back door, with good cause.

There is no reason why they have to pick up a rifle and go out front and defend this place because they lost. Clearly, they lost. All the way across the board they lost. Representing special interests and this, that, and the other thing, whatever it is that the public threw out -- pessimism, the past, all that sort of thing -- they were rejected, but they still have their muskets. Each one of them has a vote, and they are standing by the back door

saying no way are you guys going to get away from this one, and so there they are.

Now, Ronald Reagan can get us out of the Alamo. Ronald Reagan today, according to Republican pollsters, has a 72 percent approval rating in this country, and I find that out when I go back home and make a speech like this. I get all kinds of nasty mail, saying why -- I haven't made the bad part yet -- why do you say something critical of the President, because I happen to be a messenger who is trying to talk to them about some of the problems that this illustrates -- "Budget Panel Reaches Stalemate" -- and they would rather shoot me than pay attention.

But we do have a very popular President. Everybody is waiting on his every word. Everybody is waiting for him to say where do we go, and all he has to do is say I am in charge. You know, like Al Haig used to say I am in charge. Remember that?

(Laughter.)

You probably don't remember Al Haig, but -- yes, sure you do.

(Laughter.)

Just waiting for him to say I am in charge and let's go. You know, let's take off. And the reality is that if the President decided to lead us out of this charge everybody would follow, including the Democrats. The

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Democrats know he has got it, so just follow him.

But the problem is the President has decided not to take the lead in the problem, in solving the problem. What is the problem?

The problem basically is that while everything looks great and the stock market looks terrific, and all that sort of thing, behind it people are deeply worried about the difference between the dollar and everybody else's currency. People are deeply worried about a $2 trillion national debt climbing to 3 trillion. People are deeply worried that as far as the eye can see, with the most optimistic economic projections, we are going to run a $230 billion a year deficit.

And that worries some people. Maybe it doesn't worry everybody, but I guess if I were an investor in something long term like a hospital I would be worried about that sort of thing.

But the stock market goes right along. Everything looks great.

So we aren't worrying about it. We aren't worrying about the fact that the annual deficit was running when the President came to office at about $40 billion a year and today it is 230 and it is 230, 230, 230 as far as the eye can see. We are not worried about the fact that the annual debt service on that in 1980 was $42 billion, this

year it is 137 or $142 billion, and by the time the President leaves office it will be almost $200 billion per year, gang, per year.

And I think we are a little bit worried about that, and that is why we have kind of an Alamo mentality among us Republicans in Washington today. We would love to bust out of this thing. We are ready to take on something tough. All we need is the President to say go. And go where? Go to something that folks can relate to, that can identify with fiscal responsibility.

And you all know what it is. The President mentioned it in his State of the Union speech. It is called a balanced budget. It says live within your means. It says raise enough money to meet your appetites for spending.

That is measurable. Governors do it every year. Did you do that in Tennessee? Did you balance your budget?

VOICE: Yes.

SENATOR DURENBERGER: You weren't one of the Tennessee governors that got indicted and thrown out of office?

VOICE: No.

(Laughter.)

SENATOR DURENBERGER: Okay. All right.

(Laughter.)

Well, maybe you should run for President. That

is a hell of a record.

(Laughter.)

So, you know, that is the quandary, if you will, that all of us are facing. Now, we would love to see a balanced budget, but all the President has given us is a Constitutional amendment, and if a Constitutional amendment could balance the federal budget, we would pass a Constitutional amendment, and you would all vote for it when it got back to the states. But Constitutional amendments don't balance budgets.

This sort of thing does. I mean, either you freeze Social Security or you don't. Either you reform the Medicare system or you don't. Either you get some restraint in defense or you don't. Either you -- you know, whatever it is. It is a whole variety of individual decisions, individually taken, over Amtrak and farm credit and tax breaks, and on and on and on and on. That is what balances budgets.

So if balancing the budget is a way to bust out of the Alamo, then our problem is we ain't got no leader, because our leader says we got to balance the budget but he is not willing to help us do it.

He has proposed for us a budget deficit of $144 billion in 1988, and he says that is the best he can do. So clearly we can't shove him into the front door because he

just isn't going to make it and we just aren't going to follow. If that is the best we can do, Mr. President, then don't ask us to take on the elderly, don't ask us to take on the poor, don't ask us to take on Amtrak and the farmers and the middle class subsidies for this, that, or the other thing and the Small Business Administration, don't ask us to take that all on if it only gets us to a $144 billion deficit in 1988.

And that is it. I mean, it isn't a battle over defense, it isn't a battle over what kind of Republican you are or any of that sort of thing. It is as simple as wanting to answer the American public's demand that we live within our means as a way to make sure we do things better for less.

Now, what is the President really up to? I hate to accuse him of anything, but I listen to him, and I think I hear the old General Electric speeches, and I think what he is really up to is getting the federal government down to the point where it handles national defense, it handles Social Security -- only because we are stuck with it. If you read the General Electric speeches, there was nothing in there about saving Social Security -- and paying interest on debt and, because the Constitution says, maintaining the currency. I think if he had his way we wouldn't maintain currency either. But I think that is the basic objective.

Why are we in railroads? Why are we in Small Business Administration? Why do we have this tax break and that tax break and IDBs and IRBs and MRBs and BBBs, and all that sort...? Why have we piled up this 109 different programs, you know? Why do we have all these agencies, and all that sort of thing?

We are wasting an awful of money. Get rid of them. I think that is the President's thesis. That is the President's thesis, and a wonderful way to get rid of them is the pressure of the deficit to do it.

We have set ourselves up to a tax spending, government spending -- not spending, just government spending -- the Grace Report, burning money, all that sort of thing sets us up to beat on the folks in Washington who spend money, but there is a lot more spending that you are going to hear about -- and this is apropos this speech today, I guess -- that you are going to hear about that goes on that is government spending, but you do it. We just encourage it. That is the private spending that gets done under the aegis of the Tax Code, and as Mike knows, many of you know, I am an expert on that subject because I sit there every year and write up a tax bill, ever since I have been in the Senate.

On December 3rd, I think it was, the Wall Street Journal, which is a terrific newspaper until you get to the

editorial page where it has sort of got a one-track mind -- and most of the time I agree with that track -- but the very first editorial they wrote on government spending, part one, on the flip side of it was a quarter page ad for single engine Cessna aircraft, and they had -- the headline was "Two Reasons To Buy Cessna Single Engine Aircraft," and I never got to the second one because the first one said the IRS will give you all your money back, all of it, and then they explained how you do it.

You all know how you do it. ITCs, ACRS, you know all that sort of thing.

They explained how to do it. You get all your money back for a single engine aircraft.

Now, folks, that is the other side of spending, and I don't want to stand here and be critical of three-martini lunches and all that sort of thing, but you all have to face the reality that that, too, is spending at a time when this country has a $230 billion a year deficit between its willingness to pay taxes and its willingness to say no to spending side.

While we are talking about freezing spending -- and we are all talking about that. Freeze everything in place -- your letter we laughed at. Sorry, but, you know....

(Laughter.)

I said, what the hell, this a Republican organization. They don't agree with the President. What is wrong?

(Laughter.)

You all didn't know that, but the head honchos here got out a letter saying you are not going to cooperate in the freeze. So...

(Laughter.)

But anyway, we are all for freezing you and we are all for freezing defense and we are all for freezing all that sort of thing. But while we are freezing the direct government spending that we do, the spending you do with tax dollars or revenue foregone will go up next year from $32-- it will go up $44 billion, from 327 billion to 371 billion.

Now, in the name of fairness and simplicity and all of the things that seem to be driving the American system today as we try to change the way we are doing things, tell me how can I freeze food stamps when I let the three-martini lunch go. You know, how can I eliminate operating subsidies or capital subsidies for mass transit in urban America when I am letting those single engine aircraft roll down corporate America?

And I ride in some of your airplanes once in a while, so I don't want to directly criticize these things,

but....

(Laughter.)

You know, I just -- and I am not saying this to be critical of one side or the other. I am trying to say what I believe the American public will soon have to deal with.

So anyway, while we freeze this in place, that kind of spending, up goes the private spending 44 billion, up from $327 billion this year to $371 billion this year, and people will end up saying Mondale was right, Reagan did raise taxes 44 billion, the tax of debt. The tax of debt went up another $44 billion this coming year so all of us can have today and continue to send the bill to our kids.

That brings me to my second favorite subject, which is having, having and not paying for it. That is what has got us all in trouble in this country, and one of the great havers is Lee Iacocca. I don't know why, but I find myself taking him on at all of these meetings. It is because Joe Califano usually comes on the same program. He is not on here, is he, but...

(Laughter.)

Anyway, the other part of the news today -- I think it was in the Post, but it didn't make the Times Picayune because they don't know who he is maybe -- but "Chrysler Cuts U.S. Plans." Okay, the message of "Chrysler

Cuts U.S. Plans" is that Lee Iacocca is going to get even with Ronald Reagan. He is going to take 20,000 jobs outside the United States, and I say to Lee Iacocca go, go, you are too damn expensive, get out of here, take them, take them and go, we can't afford them any more at the prices that you are charging, and I say anyone could have been successful enough running a car company in the last four years to write a book about himself with all the handouts that they got.

The Chrysler bailout was not just Chrysler. It was General Motors and Ford and even AMC, I guess. That is our fourth car company. By keeping Japanese competition out of this country we were able to have today -- we were able to have 44,000 extra United Auto Worker jobs. We paid for that $15.7 billion in new car prices. That wasn't just cost of living increase. That was on top -- that was the cost of keeping Japanese cars out. You paid $15.7 billion more for those cars to save those 44,000 jobs.

(End Side 1, Begin Side 2.)

12 of those $25 are a tax subsidy paid by you as you pay taxes. So part of that tax subsidy of course is fringe benefits, amounting in the neighborhood -- the tax subsidy amounts to $23,000 per employee per year, which is nearly -- and nearly 13.5 percent of that is free health insurance, which brings me again to having.

Free health insurance. They are still doing it

at the automobile companies. They are still talking about restraint in health care. They are still talking about competition and choice and getting control of things, but they are still handing out these freebies up there in Detroit.

Now, I got one auto plant. They make small trucks. Ford Motor Company in my state. But I got a whole bunch of farmers, and I want to tell you something about farmers. Farmers don't have health insurance paid for by the government or paid for by themselves. They don't have price subsidies of the kind that Chrysler has. You can talk about cotton and tobacco and corn, and so forth. None of those things have done them a damn bit of good since 1980.

They don't have $25 an hour pay. They don't have unemployment compensation. They don't have access to AFDC and Medicaid. They don't have any quotas against foreign competition. They don't have any equalizing subsidies against the U.S. dollar which makes grain sold by Canada to Russia 36 percent cheaper or 34 percent cheaper than our grain or Argentine grain 79 percent cheaper than U.S. grain. They got to fight that 79 percent difference. There is nobody there to protect them like there is to protect Lee Iacocca.

The farmers don't have any subsidy on their equity the way you have on your hospitals. They don't.

Now, I am not here to make the case for all the farmers. I am just trying to say that there are different ways to have in America today, and when you un-have, it falls differently on different people. And the farmers are just like the rest of us. You know, they had $200 an acre land, and when we got into a bind with the Arabs in 1973 we said the only way we can un- -- get out of this bind is to get a lot of American agricultural products sold overseas to eliminate our trade deficit. So we told the farmers to plant fence row to fence row. How were we going to get them to plant fence row to fence row? We had to get more people into the farming business. How do you do that? You give them free money. How do you give them free money? Well, you create a farm credit system that hands it out.

So that is what we did. Now, what happens when you have an excess of demand over supply? The price goes up and all that sort of thing. You know all about that. So we had $200 an acre farms all of a sudden went up to $2500 an acre. Well, folks, today they are $800 an acre. I think you know all the reasons why.

If I were to come into your home, your $200,000 home, that was now worth $65,000, I would find you sitting around beating on Washington like that, saying, you know, I just lost $135,000 worth of tax deductible borrowing capacity. You know, you took $135,000 away from me,

Senator, and I can no longer go down to the bank and borrow against that $200,000 equity and then pay -- charge the interest off on my taxes and have you subsidize whatever I spend that on.

So you are still up there at $200,000, and wherever it is, whether it is your hospitals or your whatever, you haven't paid the same price that they have paid.

And a lot of that difference is in the way the marketplace works. A lot of that is in the problem we all got ourselves into with free money in this country, free sick care. You know it all created an unlimited demand for services. You know there was no limit on price, there is no limit on supply. We got more doctors than we need, more hospitals than we need, more high tech than we ever dreamed of. I mean, they are off now even not asking the FDA for permission to do wonderful things.

So that all comes with an unlimited demand and includes the fact that there is no incentives in this country for staying healthy anymore.

So that is our problem -- ours -- yours and mine and Henson Moore's and all the rest of the speakers here. What do we do in our little area? Don't worry about the farmers. I just had to get that off my mind. Don't worry about the auto workers. Somehow we will get even with them.

(Laughter.)

I don't know how, but...tax cap, yes. A lot of good that would do.

But just our little deal. Our little part of this is just like the rest of them. I mean, we are all suffering from the oversupply and the over-demand and all that sort of thing, but now we are doing something about it, and I have talked to you in past years about your role in doing something about it, and I am not going to stand here and praise the free enterprise system and the for-profit system and all that sort of thing.

But what are we doing about it?

I told you I was in Dallas last week, and when we got to the question and answers, which I may be smart enough to run right through with you people -- you couldn't hear that one in the back, huh?

(Laughter.)

That is where all the questions are.

An ophthalmic surgeon got up in a Q and A with a British accent. He turned out to be from Australia. And he says, why is it that in Australia, cataract surgery, we only get $140? In the United States they get $1500.

That is one of the things we are about in this country today, and what are we doing?

We are changing the incentives by ending the free

lunch. We are reducing the demand by pricing the product, and we are fostering innovation and quality in health care by developing consumer choice, and we are doing it together, and it doesn't make any difference what Don Maran says when he comes in here and says we are not doing policy this year. You are doing policy every day, and Dave has been feeding Don that line for the last five years. We don't have time for policy. Every time I go to lunch, breakfast, or dinner with him he is saying we don't have time to do policy, but you can't stop this policy anymore. It is rolling. It is rolling, and you are just a part of it, and you are an essential part of it. It is almost out of control. Politicians would like to be able to control this, but we can't anymore. It is consumer choice, competition, innovation, putting prices on products, changing incentives, ending the free lunch. All of those things are happening, and the responses out there, we can't keep track of those either.

I am trying to write a book, you know, about all the wonderful things that are going on in health policy. Then I am going to ask you to buy it, and I will write it.

(Laughter.)

But I can't keep up with it. And finally, the guy that is helping me write it says, Senator, you are not writing a newspaper, you are writing a book. He says, you

know, don't try to get everything in there.

But that is what is happening out there. Man, it is just -- it is terrific, you know, if you believe in this sort of thing.

But there are some folks that aren't believers.

I imagine most of you run to the Wall Street Journal, and that wouldn't happen in the nonprofit sector, but....

(Laughter.)

"Hospitals In Cost Squeeze Dump More Patients Who Can't Pay Bill."

Is that what is going on out there? You know, changing the incentives, banning the free lunch, reducing the demand by pricing the product, fostering innovation and quality of care. Well, that is good news. You are supposed to do that -- incentives, end the free lunch, reduce the demand, put a price on the product, foster innovation, quality care. That is all good news. That is like the politician that does what he is supposed to do rather than the politician that doesn't.

But when you don't do what you are supposed to do, here -- you know, this is all the stories about some of you in this room, you know, who have sent people 77 miles to get care and they died on the way, and all that sort of thing. This isn't all the stories. I am sure there is many

more of them out there, but that becomes the headline, and so there is a little bit of confusion out there in America today about what is really going on.

See, we have the notion that hospitals are public utilities, and most people don't know this but when I talk about national health insurance I talk about hospitals, you know. Hospitals are the national health insurance system. Everybody who comes in the front door gets taken care of before they go out the back door or the front door, as the case may be, and that has been an American tradition and everybody has that in their head that you got to take everybody that comes in the front door.

Well, that is just part of what got us in trouble. If you have to take everybody that comes in the front door, you have got problems inside that door. Competition doesn't work. The marketplace doesn't work. Incentives don't work in that kind of a system because depending on where you are located you are going to get a whole bunch of poor. Depending on where you are located, you are going to get a whole bunch of elderly, depending on, you know, all that sort of thing, factors over which you don't have any control because the building can't be changed and relocated every couple of years. As society changes, the whole definition of a hospital changes.

And we in the public side can't deal with the

problems of cross-subsidies. If we admit to the fact that you have to take everybody and you have to do everything inside this box, then we will never be able to adequately take care of the poor. We will never take care of graduate medical education or anything else if we ever accept the notion that this is a franchised utility system in which everybody does everything for anybody who happens to want them to do it.

Now, that is heresy in America today to talk like that, and you are all responsible for that heresy. Any one of you who went into the health giving, healing professions are responsible for that, and I am responsible for that.

But we have to change the way we do things, and on our side in the federal government, on the policy side, I will just quickly tell you before the panel gets here to dissect what I have to say and tear it apart and throw it away the things that we would like to do if Dave Stockman and Don Maran would let us do it.

Expand the prospective payment system in Medicare to all providers, with some differences between surgical and other doctors in the way they are involved in the prospective payment system.

Develop a severity index as quickly as possible so we can get to a national average for prospective payments without regional or urban/rural differences and with limited

indirect medical education.

Develop an explicit financing system for graduate medical education, and hopefully Bob Dole and I will have one on the street within the next couple of weeks.

Restructure the Medicare system, put in prevention and wellness benefits. You know, I have got a wellness benefit in now that I quit smoking. I have got a lifestyle tested premium in there. So if you smoke, you pay more. I also joined AARP. That should come as good news for some of you. Tell you how old I am.

(Laughter.)

You only have to be 45 now to do it -- no.

(Laughter.)

Co-pay or some other kind of cost sharing so we can provide catastrophic.

Reduce the Part B premium and means test the benefits off the premium.

And continue the demonstrations to move the Medicare system closer to social services.

And by doing all that, to try to eliminate the inefficiency of supplemental insurance in Medicare and eventually get us to the place where we can pretty generally get out of the insurance business and turn that over to competitive medical plans. The competitive medical plans are already on the street. Some of you I am sure are

organizing them or buying into them or capturing them or doing something to them. If you are smart, that is what you will do. But the competitive medical plan is the future of Medicare.

On the issue of capital -- I guess you heard -- I don't know whether you have heard anything about capital. I heard conflicting stories about what was said about capital, but HHS is supposed to bring their November report out in April this year.

(Laughter.)

And we will anxiously look forward to that and all the options that they will give us and then ask Dave Stockman if we can do something about it.

We will by October 1 of 1986 meet our deadline to do something about moving capital through the DRG system, principally because I hate franchising like CON and 1122 and all those other alternatives we put in there. I would really like to see us do something about.

But the real capital issues will come quicker than I thought -- now that I deal with the reality of this -- quicker than I thought when we get to tax reform. That is the last part of my little sermonette today.

The flat rate tax. Most of you have written me about it before you discovered what it was and said you were for it.

(Laughter.)

So tax reform. And the reason it is coming sooner rather than earlier is because the reality is this isn't going anywhere for all the reasons that I talked to you about earlier.

Now, don't abandon the stock market. Don't rush out and panic, but my best judgment is that on the basis of what I told you a half hour ago we aren't going to get anywhere this year on deficit reduction only on the direct spending side. That means that the burners will start turning up on taxes in some way, and the easy copout is to do a 20 percent import surcharge or some other kind of, you know, quickie tax, and imports are a great place to go because they are flooding the market and all that sort of thing.

But the President says no taxes. So if the President stands there in the front door of the Alamo and won't let us through, then we won't get any of that. But tax reform is coming.

The flat rate tax I won't try to sell to you other than it is basically a good notion, only because it gets rid of a lot of lobbyists, or at least a lot of the issues. The lobbyists will still be around, but a lot of issues.

But as it relates to capital, the flat tax --

most of the flat taxes -- you know because your tax lawyers have examined them -- eliminate private purpose tax-exempt bond financing, and you know the history of how we have grown from -- you know, to just live off of tax-exempt bond financing. It is going. It is going. I don't know how quickly it is going, but it is going. It isn't even good the way it is now because it has got -- like IRBs have this $10 million cap in them or something like that, but not -- the nonprofits don't have a cap. Just the for-profits have a cap. You know, so we will screw it up unless we get rid of it.

So probably you will see it go. I don't know what it will be replaced by. Will there be an instrument that permits the public sector, whatever that is, to borrow at something below market rate? I don't know. Will there be the old general obligation bond in control of the local community? I am not sure. But I know that if you have been relying like 80 percent of the hospitals in this country have been relying on tax-exempt in any way, there is a problem.

You all know that most of these flat rate taxes eliminate corporate welfare. The investment tax credit, whist, out that goes. I don't know how many of you rely on that. Out that goes.

You know that they all lean in the direction of

expensing rather than depreciation for cost recovery. That would really lay a bomb in this room. But watch the way they lean. I mean, see how they are leaning. See how they are leaning.

You know that at least the Treasury, one, intends to go after tax deductible contributions in some way, and this is the point at which I always raise the specter of getting rid of the difference between for-profits and not-for-profits, and I said that in Miami last week and Chip got a hundred phone calls. But we have to think about that. I mean, you shouldn't be in business unless you can make a bottom line of some kind, and why do we continue to keep that distinction except for this reason right here, and that is what I will have to talk to Larry Lewin and all those, the nonprofits, about on Monday.

But we do a lot of artificial things in the area of access to capital because we maintain that distinction, and all I say is it is time to examine it, and it looks like at least the Treasury wants to look at contributions and that 501(c)(3) side with some intensity.

The seventh point in terms of what we are doing, the true marketplace -- and I wanted to give you a whole speech on this subject, but I just didn't have time to write it because I wanted to get more examples -- but the true marketplace requires an absolutely level playing field.

That is why I say why do we maintain the nonprofit/for-profit distinction, because that is not a level playing field and it is different, whatever it is, for different folks, see. But even in the payment system you need this level playing field.

Now, we all know that DRGs are doing a good job of driving some procedures out of the hospital, but unfortunately in some cases -- and you know about them -- they are driving these procedures to lower cost but higher paid alternatives.

For example, I forgot to bring with me the Humana and other ads that are running in Florida. I know that is where they gave me them. It might be in other places. But you got a great deal on cataract surgery, right? Terrific deal. According to the ads, you can get cataract surgery outpatient in the hospital for nothing, see, because the hospital will swallow the 20 percent co-pay on Part B because they can do it for a hell of a lot less than $1320, or whatever the 80 percent represents, or at least they can do it for $1320. But at the ambulatory surgery center in the same community they are getting $700 for it.

Now, what is a poor policymaker to do when he comes to the for-profits and says am I really doing that? Well, what he does is call Carolyn Davis and say why are we doing that?

I don't blame people for doing this sort of thing. If we set up the playing field so it is like this, well, I don't blame somebody for taking advantage of it.

Or SNFs. A hospital SNF is 90 to $95 per diem, and a free-standing SNF is 50 to $60. That is where I wanted to get a whole bunch of other examples, but you know all the examples.

So to be honest with you, that is going to level the playing field. You got to level the playing field, and it isn't too level.

Let me finish with the poor, the medically indigent, whatever we want to call them, and this hurts, and this really hurts for a Republican because Republicans are not supposed to be sensitive to the poor. But any of you who are in the hospital business worry a lot about this issue because you are in the health caring business. Yes, you are in a business. Don't ever apologize for that. But you are in the health caring business, and this bothers you.

But if you ever get to the point where you say, well, I will take on my 20 percent or I will take on my 25 percent, or something, I am going to say, hooray, they did it. See, and particularly if I am a local or state politician, I will say, I got them, I got them, they agreed to take it on again and cover up all those subsidies. Now I don't have to worry about the poor anymore.

See, and that is -- this is a really tough thing for a politician to deal with because if I really believe in competition and I really believe in making you more efficient and bringing down those costs, then I know those subsidies are coming out of the system, and we have to deal with the poor in particular, and it has to be dealt with at my level and the state level and the local level. But today I am not dealing with it. My President says cap them, cap them. He doesn't believe they are getting sicker or poorer like I do. He says cap them, cap Medicaid.

Boy, that hurts.

Now, there are some states that can pick up the difference, but I don't know about Cook County. I don't know about L.A. General. I don't know about Charity Hospital out here. I don't know that they can do that.

Now, what I do know is they are putting all their money into sick care and nothing into prevention, and I hurt when it comes to prenatal care and all those things you can see where if we just put a few bucks into some of those sort of things we could reduce the cost over here, but it isn't there. See?

So that is the really hard issue that I know you have committed yourself to and the American Hospital Association has committed itself to and employers have committed themselves to, and a whole lot of people have

committed themselves to try to solve that problem. All I say to you is in solving it don't let the politicians off the hook. Don't let us say that there is no responsibility for the poor at the national level, that that is a responsibility only for state or local government. Don't ever let us say that. Don't ever let us get away with saying people should vote with their feet, and then when it comes to the state and local level put that same pressure on them.

And, yes, it is a lot easier to build or replace Cook County General than it is to give vouchers so they can go to Rush Presbyterian or they can go to University of Illinois or something across the street because those county commissioners like to see new buildings open up, and that sort of thing. But that is the wrong thing to do. Tell them what the right thing to do is. Tell them you will take these people on but they got to come equipped like everybody else to get the best service in the world, or at least in the community, which you believe you provide.

I finish with a Chinese proverb that I learned from a China man. That is where all proverbs come from, I am sure, at least all Chinese proverbs.

(Laughter.)

But the old man and his grandson were traveling across their province in China with a mule, and the boy was

riding the mule and the old man was leading it, and they went through this town and everybody was standing on the side saying isn't it awful that that healthy kid rides up there on the mule and makes the old man walk in the dust?

So they got to the end of the town, and they decided they better switch places. So they switched places. And they got to the next town, and they could hear people saying isn't it awful that that old man sits up there on the mule and makes that poor kid walk in the dust?

So they got to the edge of that town, and they had a long conversation, the result of which they lifted the mule up on their shoulders, and they are walking off to the next town. They were walking over a rickety bridge over a river and they lost their balance, and the mule went over the side of the bridge and fell into the river, and the two of them were leaning over the edge of the bridge there watching the mule drown, and the old man said -- looked at the son and he said, now, son, let that be a lesson to you -- and this is sort of the lesson of this speech -- if you try to please everybody, you are going to lose your mule.

(Laughter.)

Thank you very much.

(Applause.)

(Whereupon, the address was concluded.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

9/30/86

GENERAL ELECTRIC

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SPECIAL
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HEARING
EX. 221

VOICE: Welcome to a weekly news conference with Senator Dave Durenberger. Today's reporters are Todd Moe, with the Minnesota News Network, and Sue Lafond, with Radio Station WYSM in Mankato.

Todd will ask the first question.

MR. MOE: Thank you, Nancy.

Good afternoon, Senator.

SENATOR DURENBERGER: Hello, Todd.

MR. MOE: On kind of an international level here, the Soviet Foreign Minister, Schevrednadze -- I think I'm pronouncing that right -- was somewhat critical of President Reagan today -- President Reagan's address yesterday to the UN and he says a summit meeting is still a realistic possibility, Senator, if the US is willing. What's your reaction to his comments today? Do you have any?

SENATOR DURENBERGER: Well, I think this is just propaganda, public relations, part of the back-and-forth over whether there will be a summit and, if so, what the agenda will be, when it will take place, complicated by the Daniloff-Zacharov situation. So, I think today's statement by Schevrednadze is just, you know, the tit-for-tat of public relations and propaganda.

MR. MOE: Do you think the whole Daniloff

situation is being blown out of proportion?

SENATOR DURENBERGER: Well, I think any time you take an individual case and make it the center piece for your national security policy or any phase of that policy, that's disproportionate. The reality, however, is that there is more to all of these cases than meets the eye, and when it becomes the center piece of public attention, it's much more difficult to deal with some of the realities that are still unknown by the general public. So, the President is in a very difficult situation in this case. Gorbachev is also in a difficult situation. I think the end result will be that there will be some mutually face saving way to come out of this.

The unfortunate thing is that we're losing sight in this whole process of the incredible amount of spying work, espionage work that the Soviet Union is doing in the United States in some very open ways, diplomatic ways and non-diplomatic through the UN and through their Embassy.

Early next week the Intelligence Committee on the Senate side, which I Chair, will go public with a report that it's been working on for better than a year on the degree of lax security in America and the espionage problems that we experience with regard to the Soviet Union in particular and some other countries, and I think the public will then be reminded that there is more to this case than

meets the eye.

MS. LAFOND: Senator, last week you said that the military isn't necessarily the best people to use to fight against the drug war on our borders. Who or what would be better way to help this situation?

SENATOR DURENBERGER: Well, there's two ways to deal with the problem. One is clarifying the law, and the second is having an adequate number of trained personnel who are trained specially to interdict criminals. We do not train our Army, Navy, Air Force and Marines to deal with criminals. Some elements, the Shore Patrol in the Navy, the MP's in the Army obviously have training in civil disorder and so forth. But, your normal soldier is not taught to deal with criminals. The drug dealers and smugglers are hardened criminals. I mean, they kill people right and left, and you'll notice that when any of them are caught and there's a possibility of putting them on trial they come up and find some way to kill off the witnesses.

So, this is a very different breed of animals we're dealing with and only trained personnel can deal -- and I think there is a growing number of trained personnel being put to work on this problem but the borders of the United States are large and porous.

The solution to this problem, therefore, is not just keeping the drugs out of this country. It's keeping

the drugs out of Americans.

MS. LAFOND: Is this a part of the proposed drug legislation that you have --

SENATOR DURENBERGER: Well, the heart of the drug legislation is the kind of things that the states, like Minnesota, have been doing for many, many years. That's dealing with the problem of substance abuse and chemical dependency. That is a problem that's been around since the beginning of time. It's gotten worse over the last 15-16 years. Those of us who should be dealing with it have not been properly equipped by education to deal with it, nor have we properly supported institutional resources in the area of education and in the area of prevention and in the areas of treatment and rehabilitation.

Minnesota is unique in having spent millions and millions of dollars per year since the mid-1970's in getting adequate education prevention treatment and rehabilitation. But the rest of the states haven't been doing it and one of the good things about finally getting the national government off its duff and doing something, even though it's sort of a political things it's doing, is that we might devote some national resources to a legitimate national purpose and that is stamping out the disease of substance abuse, and it is a disease which is prevalent throughout this country.

Research is necessary, education is necessary, and like any other disease, treatment in the specific case is necessary. But that costs a lot of money and, you know, combined federal, state and local resources and private resources are going to have to put into this battle, not just this legislation we're acting on now.

MR. MOE: Senator, I wanted to ask you about the reconciliation bill for Fiscal 1987. You've had a hand in that. What's the status right now?

SENATOR DURENBERGER: Well, we expect that it will be passed by the -- hopefully, by the middle of next week. It's all tied in with Gramm-Rudman-Hollings and the deficit reduction. It's tied in with the continuing resolution which is necessary before we can adjourn and begin Fiscal Year 1987.

There is a lot of good new legislation in budget reconciliation this year in the health care area, which is in large part my doing: Medicare changes, reduction in the increase in the Medicare deductible for the elderly from -- bringing that down from $574 to $520 -- which is still not affordable, but it's closer to affordability for the elderly, adequate compensation for hospitals, increases in the compensation for rural hospitals, preventing the administration from cutting into payments for kidney dialysis and things like that that are in there.

In the area of the indigent, I've got two pieces of legislation that are in reconciliation and hopefully will become law that will help pregnant -- particularly first-time pregnant women with prenatal -- adequate prenatal care, and this is in the Medicaid program.

MR. MOE: Are you optimistic that it will pass without being picked apart too much?

SENATOR DURENBERGER: Yeah, I think the House has one version; we have another. There's enough similarities, other than in the financing mechanisms, that it shouldn't be too difficult to put together.

The financing problem is always that we have one set of -- small set of taxes; the House has a different small set of taxes, including an import tariff or surcharge on imports, and that could be kind of a battle that potentially could sink the ship for some period of time.

Sue?

MS. LAFOND: There's been some doubt about -- on the tax reform passage, whether it will pass or not. Which way do you expect the vote on the tax --

SENATOR DURENBERGER: I think the vote will be Thursday of this week in the House and it will pass -- oh, probably get about 70 percent of the House Members to vote for it and then probably sometime early next week, which is supposed to be the last week of this session, it will be

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presented and passed on the Senate side. There probably will be a lot of debate over it. Maybe a third or so of the Senators will vote against this one because it's different from the one we sent to the House.

We sent a very good bill to the House. This is a less-good bill, if you will, because of changes that were made from the House bill to the Senate bill. The bill is not as good as the one the Senate passed, but I think it's the only one we have to deal with so we have to support it.

Todd?

MR. MOE: Senator, ag officials and farmers around the country, including here in Minnesota, are calling for a new federal farm bill. Apparently, the first one isn't doing any good to farmers. I guess, Senator Harkin from Iowa introduced some legislation.

What's your opinion? Do you think the Reagan Administration is doing enough for farmers right now?

SENATOR DURENBERGER: Well, I think they're doing all that they can do and the only consensus that we can get. I mean, this is the -- you know, this is the payoff for 20 years of doing the wrong thing and no one piece of legislation is going to change it.

If Tom Harkin thought he had the right answer, you know, he could have done it in 1985. But, he didn't. He wants to raise the cost -- we're spending $30 billion

this year on farm income price supports and he wants to raise that higher.

So, the problem is 20 years of inflation, over-production, boycotts, embargoes of legitimate markets and all that sort of thing. It's just a whole series of lousy farm policies that now result in near disaster in American agriculture. But we'll come back from it.

But I don't know. If anybody's got a magic answer for how to get back in a hurry, we haven't heard it here in Washington. Anything we do, we're going to have to do carefully and we're going to have to do over a period of time. There just aren't any readily -- ready to hand, easy solutions to this enormous economic problem.

MR. MOE: Maybe as a follow-up, last evening Government Purpech was addressing the farmer's plight of Minnesota in his debate with Cal Ludeman and mentioned that his hands are sort of tied. He said the farmers' plight is somewhat -- that the federal government is somewhat to blame for that and he can't change any of that legislation himself.

SENATOR DURENBERGER: No, that's -- he can't -- Purpech doesn't understand that there's two sides to this ag economics thing. One side is 20 years of bad national policy in which everybody cooperated. It wasn't as though it was an evil scheme.

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The other side of it, though, is that the Governor could do something about it in Minnesota. Minnesota ranks first in farm foreclosures, it ranks first, I think, in the amount of drop in equity value of farm land because Minnesota has done little or nothing itself as a state to help arrest the decline in agriculture.

The Governor had been willing to spend $2 billion I think to bring a General Motors automobile plant into the State of Minnesota, but he hasn't spent anything on trying to add value to Minnesota agricultural production. If he spent that kind of money, $2 billion, in tax incentives, other kinds of incentives to plants that processed corn and soybeans and processed meats and so forth, other kinds of food in our State, if that was our direction, then he could arrest this decline.

He could hang on to rural Minnesota. He could turn things around for Minnesota farmers. But I don't recall that he has ever proposed that we do that sort of thing. He just sort of wrings his hands and says this is a national problem and I've been to Washington and they don't listen to me and, of course, they don't listen to him in Washington because he doesn't do in Minnesota the kinds of things that he could do or he could get the Legislature to help him do that would turn that ag economics around.

VOICE: Thank you for joining us. That concludes today's news conference with Senator Dave Durenberger.

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
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by Senator David Durenberger

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SPECIAL
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EX. 222

(Applause.)

VOICE: That was an outstanding introduction. I'm glad I was here to hear that. It's much better than the printed stuff that in that material. I'm glad you're all here, too. I don't -- I find it hard waking up on Monday morning for some reason or other and -- I'm not sure why it is, other than the week is ahead of us rather than behind you. But for some reason or other, it's a little hard getting going on Monday morning, and so I've got to compliment all of you. I don't know whether you just got here or been here for a few days and this is a wind-up, but all of the other experts -- meaning the Senators (inaudible) -- will be back in town tomorrow. So, if you're sticking around at least long enough to go over and lobby your favorites or the ones that you have to vote for, as the case may be --

(Laughter.)

-- depending on where you come from.

I'll credit for all the nice things in that introduction. When I take credit for all the reform and everything that's going on out there somehow you either take the credit or the blame (inaudible), some of the budgetary kind of pressures, including the (inaudible).

(Laughter.)

(Inaudible.)

But anyway, you had Bill Gratison for breakfast or you had --

(Laughter.)

(Inaudible.)

Usually we wait until after you're no longer up here before we get up here to speak. So I (inaudible) bill in (inaudible) and here is a guy that when you say House Intelligence or something like that, it's not an oxymoron. Those of you who know what an oxymoron is just clap. But oxymoron is the word (inaudible) like honest politician, or --

(Laughter.)

-- or Senate Intelligence. (Inaudible.) But Bill is one of those people that, if he were Chairman of the House Intelligence Committee nobody would laugh. When they introduce me as Chairman of the Senate Intelligence Committee (inaudible) seem to make people laugh. But Bill is the Ranking Republicans. He's one of those guys that you just -- after you've heard him speak you just wonder when in the world (inaudible).

Well, let me begin right at that point. The room is probably occupied by Republicans, Democrats, Independents and I hope that's all. There's no (inaudible) in here.

(Laughter.)

(Inaudible.) Here, in the era of reform -- and even the President got off of that recently. I am here this morning courtesy of my publisher, Piranha Press --

(Laughter.)

They're a subsidiary of Northwest Publications, and three years ago -- they're run by a former gung-ho Marine commander. And three years ago -- I'd written a bunch of white papers on national (inaudible) and national security policy (inaudible) turn things around in this country. We're going to spend more money and get more (inaudible). We ought to turn them around the way (inaudible). But I have a national security policy.

He read those and insisted that I write a book on them. So I have. It's called Neither Madmen Nor Messiahs: Policy of National Security for America. It came out about a year ago, and it is sort of my guidebook on setting a national intelligence strategy for the country (inaudible) and it has now become Barry Goldwater's guideline and, to a degree, I think Sam Nunn's, what the Armed Services Committee is doing on reforming the defense side. And as you all know, Saturday the President spent five whole minutes saying he's for reforming the Defense Department.

So, we've got everybody on board now. The question is how we do it, and that's just one version of how

you do it. One Senator's version. But aside from the premise that unless you know where you are going you ain't going to get there. Unless you know where you are headed and how you -- and you're not going to be able to determine how you want to get there.

Well, one of the quandaries, one of the problems we face in America today is that we are now full of renewed vigor, renewed optimism. We've got more of a can-do spirit. We don't have to live with inflation and we know it. We don't have to live with high interest rates and we know it. We can live with a high stock market and lower bond rate and so forth if we want to.

This mood of I'm going to be better today or tomorrow than I was today and I feel better today than I did yesterday is a reversal from the time I got elected. So, in other words, we are -- we're placed in the sunshine or the sunrise rather than the sunset attitudinally. But there is still an undercurrent of concern about is this real, how long will it last, what happens after Ronald Reagan. I read more letters to the editor in my home town newspapers (inaudible) What are we going to do (inaudible). Like he's such a phenomenon he can't be replaced and he becomes the be all of the end all.

So, it is of deep concern to the Bill Gratisons and Dave Durenbergers in this world, and we not only have

optimism which is a key ingredient if we're going to get anything done, but we have some sense of direction. Where are we going.

And in the area of health care, we may not know precisely where we are headed in the financing of health care and delivery, but there can't be anybody in this room that knows how we're going to get -- that doesn't know how we are going to get there. We have changed the way Americans pay for health care (inaudible) by changing the way we pay for Medicare and thus getting everybody (inaudible) they pay for health. And we in the health care area are going to be an -- and are I think already -- a model for people in the other areas of public service delivery.

If you insist on paying hospitals rather than their patients you're going to turn hospitals into public utilities. If you insist on paying doctors for their costs or anybody else (inaudible) you are going to lose the incentives to do things more efficiently. If you are going to educate all the children in this country in public or governmental schools you're going to lose the efficiency that comes with choice of education.

I can go on and on and on with examples like those, but where we are headed generally in America today is the deregulation, if you will, of the delivery of public and

private services. Private loan company and parking lines and airlines and a whole bunch of other things, and on the public (inaudible) I call the private side you've got everything from hospitals to housing to welfare to eventually education (inaudible).

And we find the common element in it is replaced competition (inaudible) choice of services or a choice of goods and they have enough information with which to make that choice and enough natural resources that they can afford to make the choice. They are generally going to make better choices than if they operated in a public utility or in a one-choice only kind of a (inaudible).

So, the thesis for the direction in which we are moving with health care policy is simply we're not telling anybody how many doctors we have to have any more, we're not telling anybody what kind of product to sell or what hospital. We are trying only to make sure that the consumer has a choice in the purchase of health plans (inaudible) in the purchase and utilization of health care services.

We did that by switching to the prospect -- first backing off from the (inaudible) payment system first for hospitals, then for other institutional providers and then for the doctors. Some order like that. Ultimately everybody in this country will be buying their health care the same way employed persons buy their health care, from a

choice of health plans in their (inaudible) and Medicare and Medicaid and other public agencies that are third-party payers will be supporting that choice with all of a part of the premium (inaudible).

So that is the -- in it's totality is the way in which the Gratisons and the Durenbergers and the others of us are involved (inaudible) choice of health care are moving the purchasing part, the consumer purchasing part of this system through a prospectively priced set of institutionalized and individualized into a purchase from the private health plan market of health plans which plans will then negotiate with doctors, hospitals, nursing homes, you name, for the purchase of medical care. That is the direction we are headed.

We are headed there slowly, gradually. Some people say too fast; some people say (inaudible), but we are headed very deliberately in that direction. The DRG's are the prospective way of paying hospitals. We don't have a severity index. We wish we had one. (Inaudible) capital payment. I think -- I don't even know the number of my bill, but somebody in the audience probably does. I have a vastly different and -- not different, but at least improved version of capital payments.

It's S.2121. I even remembered. It's a seven year transition into capital, rather than a four year

transition, and it starts off with the hospital specific portion. A much greater part of the overall -- I go down -- I think my percentages are like 95 percent, 90 percent, 85, 80, very slowly, and then all of a sudden at the end (inaudible).

But my view of capital on hospitals specifically is that it is a small part of the total cost of (inaudible). It averages 7 percent percent or something like that across the board. So why try to kill off a bunch of hospitals who are over 7 percent, if we're really just -- if we're trying use the 93 percent. This is a reform. And we are making the reforms of the 93 percent, and we do have some hospitals that for one reason or another just had to get up into the 12, 14, 16, 18 percent bracket. It just doesn't make any sense to (inaudible) those people the way the President (inaudible).

So, the Capitol version we hope will pass this year (inaudible) try to get them to see the merits of doing it. So if we can get a severity index on hospital prospective -- if we get a capital folded in there, we maintain that the -- President signed --(inaudible). So when he signs the reconciliation -- we have in there graduate medical education reform which are really fairly important to a lot of people, and we have some other smaller reforms that -- a disproportionate share of hospitals and

(inaudible). Now we're going to expand that DRG to include (inaudible) and to include other kinds of institutional providers.

In reconciliation we also have a mandate to the Secretary of HHS to come up with a position prospective payment system by July 1 of next year. (Inaudible) payment commission and (inaudible) October 1 or November 1 (inaudible) 1987, and then get it into effect by January 1 (inaudible) probably isn't because we intend to go (inaudible) the DRG. We may go to a DRG in the surgery (inaudible). Beyond that, generally, a physician (inaudible) compensated prospectively on the basis of a relative value system which is something that the doctor can recommend to us (inaudible).

And now that we've got free trade going in health care delivery, the RVS is a more appropriate way to go about doing that. So, at the same time, we are pressing (inaudible) on competitive medical plans, which is the private sector health plan choice we want Medicare-eligible people to utilize. The same thing that you had at your place at work. Hopefully you are in communities where people have (inaudible) health plans. Hopefully (inaudible).

We're taking the same notion -- I've just used myself as an example. As a federal employee my employer

gives me $126 a month (inaudible) but they give me a (inaudible). So I am entitled (inaudible) to $126 a month. We can use that to buy -- in our case it's about 20 to 24, 25 different health plans, which boggles the mind (inaudible). But we then have got to make our choice in health plans with that $126 (inaudible).

That same sort of thing is happening now in Medicare -- happening very substantially in (inaudible). The numbers are not large. I think they're something like 22,000 -- maybe close -- I think it's 50,000 (inaudible) who are in -- buying -- Medicare eligibles who are buying (inaudible). So, that's the way we will be competitive with most of the (inaudible).

We will do the same thing with regard to the indigent because it is much more appropriate for the indigent to buy their health care the same way as everyone else buys their health care, though private plans from doctors and hospitals, rather than being shoved into a public hospital and (inaudible). Much more appropriate for them to buy their health care the same way everyone else buys theirs.

So that is the -- I know I've left out some details which I will leave to your questions, but that is the direction we want this system to head, and along the way we're getting a hard time from the Administration because we

are the (inaudible). There is no reform taking place here in the Defense Department. It hasn't even started yet. All they've done is double the amount of money (inaudible). Well, we have not doubled the amount of money in Medicare. In fact, we have saved the Medicare from going over $30 billion and we have saved the trust fund from bankruptcy.

Last week I think the trustees got out a report based on pre-reconciliation information that said it looked like bankers (inaudible) and a bunch of people (inaudible) got worried and panicked. Well, hell, three years ago they were predicting that it was going to be in 1987, which is next year, we're supposed to be bankrupt. Well, it's not bankrupt because of people like you who (inaudible). I mean the incentives are now there to purchase wisely, so long as we don't tighten down that payment base. (Inaudible.) Somebody whose beneficiary is slow paid by Medicare, and you know how everybody operates (inaudible) these days. (Inaudible.)

That's not the way to get good people to be paid for doing efficient -- in an efficient manner. But there is an impression out there by some of your Senators and Congressmen that Medicare is best as a system of paying doctors and hospitals and (inaudible). We lost -- we tried to get Medicare into a favored category in Gramm-Rudman-Hollings last year. (Inaudible.)

But they took the position that Medicare is nothing but a payment to rich doctors and hospitals. Anything we can do to cut it (inaudible). So those of you who are represented by Senators like that, I hope you spend a little time dealing with the realities of the advantages of reform and how much money we are all saving if we (inaudible). They ought not to try to take any more money off the reform system by freezing the (inaudible), freezing the lotteries (inaudible).

Now, with my other hat on -- one of my other hats on, the one on reforming the tax system, and that is a -- that's a real delight. I got my first letter from Minnesota about two weeks ago from somebody -- from an ordinary person that wanted tax reform. (Inaudible.) (Inaudible) tax reform since January of 1984 when the President said the tax system was unclear and anti-growth and it's complicated and he appointed Don Regan to do tax reform and Don Regan (inaudible).

But given the President's premises, it was a very timely (inaudible). The President (inaudible). And the highest ought to be 35 and the next one 25 and (inaudible) and that corporations should pay (inaudible).

Everybody complained about it, but then -- interesting thing, after everybody complained for a couple of weeks, they all looked at it a second time and said, gee,

you know if this happens to everybody I'll be okay. So nobody heard that at Treasury because by then Jim Baker was the Secretary of the Treasury and he left the oil and the gas people out of (inaudible) and it's every man for himself.

So, H.R. -- so the House last year, at the end of 1985, one year after (inaudible), presented us with a (inaudible). The Republicans appropriately said it's too -- all it does is take money from capital formation savings (inaudible), or it takes money from (inaudible) the individual side.

So the Republicans said, no, and the President said in his famous letter to Jack Kemp, he said (inaudible) vote for the bill anyway because the Senate will take care of (inaudible). So I'm here (inaudible) doing the President's bidding. I will protect all of -- protect all the practical loopholes that I can protect in the base. But I will not be able to deliver (inaudible). If I am going to hang on to any vestige to invest in tax credits or if I'm going to hang on to (inaudible) if I'm going to hang on to installment sales, if I'm going to hang on (inaudible) small business on their (inaudible) on their capital investments every years, I'm going to go -- I'm going to do all of these things that are necessary for capital formation, then I can't (inaudible).

So I suspect that's where we will be after -- and that's obviously been the case. Nobody who watching this tax legislation can ever figure out how we can get the rates down to 35 percent without taking a large crack at capital formation because we are not yet at the point where the individual in America understands that it's their tax breaks and not the corporate tax (inaudible) that are the larger part of the problem. The larger part of the problem.

Somebody was giving me hell in a Q and A session a few days ago about consumption, stuff like that. I said, well, we're subsidizing -- we're talking about tax subsidies for (inaudible). I was complaining about the health insurance wasn't cheap. But Lee Iacocca, who I see made only about $4 million last year, also got $5,000 worth of tax subsidized health insurance free. All of it paid for by the taxpayers, whereas all of my farmers are all going broke. They don't even have health insurance. If they have it, they've got to buy it (inaudible). That's not a very fair substitution for something that is basically a consumption item, health insurance.

It (inaudible) diagnostic and (inaudible). All it does is buy you sick care then that's a (inaudible) consumption item. (Inaudible.) we don't have any consumption anywhere else. (Inaudible.) Well, what do you mean? Well, I said, actually it's really higher than that,

but that's the (inaudible) because I borrowed 15 or 16 (inaudible) -- I think I borrowed enough to cover my (inaudible), probably about $16,000 and I financed that over four years, and so over a four-year period of time, with the interest deduction, I'm sure I will pay (inaudible).

Then I have already subsidized the people who made that (inaudible) to the tune or about 15 -- I guess the latest figure is $1,600 by keeping the Japanese off the market since about 1981. We have increased the prices of American cars -- we've increased the price of Japanese cars by $2,400 by keeping the Japanese (inaudible). So something in excess of 50 percent is the subsidy in an Oldsmobile.

So, now if I am going to go out there and I'm going to try to get rid of all the subsidies, get rid of the interest deductions and all of that sort of consumption items on the taxpayers side, I suspect I'll have a great deal of influence of getting all that done. I propose to the Finance Committee in 1982 to get rid of (inaudible) and I got four other votes. That means 15 guys disagreed with me. And so where we've come since then (inaudible).

So the bottom line is that the Finance Committee will do what we believe is right, rather than gamble on the President's instinct that (inaudible) 35 percent rate -- we have so diluted the value of tax expenditures that people will not want to buy tax exempt bonds, people will not want

to get (inaudible), people will not want to do all of those things.

Our view is that only a 14 percent ratio, or a 15 or 20 or something -- a very low rate of flat tax will ever get (inaudible) people don't want to take advantage of those things in the tax bill that were put there because a higher rate of -- a too heavy reliance on (inaudible) is not (inaudible). Now the bottom line (inaudible) is that we will end up in a few weeks (inaudible) and Packwood can see it coming already and we may not even be able to finish (inaudible). We will have about a 39 percent rate and the President will have to decide whether he will settle for a 39 percent rate on his way to something lower in the future or will he vote a new tax bill. Kind of an excise tax -- the elimination of the excise tax deduction (inaudible). I think he will strongly oppose eliminating the excise tax (inaudible), or will he just sort of give up this year and come back next year.

One thing he will not do this year -- he may not do at all is (inaudible), and that is go to a national consumption tax and use it only for purposes of reducing the tax, the national tax on (inaudible). Not federal spending, but just reduce the national tax, and I don't mean just the income tax. It means payroll tax as well, which is the most unconscionable and unfair and regressive part of the whole

tax (inaudible).

Today you are all paying $6,000 for your first $42,000 and even people that work for you that make only, say, $10,000-$12,000 a year are paying (inaudible). In 1988 it goes up -- or n 1989 it goes up $8,000 per person per year, or $16,000 for a family. On top of that you pay unemployment comp (inaudible) and at the state level and you pay workers comp on payroll deduction. It's very unconscionable. The only way we're going to put a cap on that is (inaudible) national tax system off of it from it down to consumption. We can do that several ways. You can just take the income tax and cut it down the middle between income that is saved or invested (inaudible). Tax only the part (inaudible). Do not tax savings or investment until they come out and are (inaudible). Very simple way to (inaudible) Income Tax Code. In fact, if we did it that way, we could probably (inaudible) security system by the year 2,000. If we put that into effect today so we'd have half a generation of people who knew that every nickel and dime that they saved, regardless of what kind of account they put it in, they just saved it or invested it, was not going to get taxed it could mean (inaudible), which it was in 1935. If we could get back to 1935 by the year 2,000.

The other ways of doing it are a little more explicit: National sales value added tax, which is a, some

people say, more preferable way of doing it. In the case of the sales tax, people can see it and they can do something about it. In the case of a value added tax, well, they can't see it and they don't want to see it (inaudible), experts say. It is more directly at the point of (inaudible) a service.

But the proceeds from that -- a 10 percent sales tax, for example, and a value added tax across the board, no exemptions -- refundability built into it at the lower end so you can alter your income tax table to adjust to how much people will spend (inaudible) sales tax at various grades of refundability to make it progressive. You can still raise about $220 million a year which should go a long way towards bringing down income tax rates (inaudible).

So that is probably where the country will head to by end of the decade or the early 1990's. Something like that. So you can count on a major tax reform system in this country. But I think the growing view is that we may have to combine that income tax reform with a consumption tax of some kind, rather than buying it all out of the base. No question but we ought to broaden the base income tax. You probably all like the investment tax credit. We're taking it away. No question about it. One of the few things we could find that is sort of across the board and it touches most people fairly (inaudible) --

(Laughter.)

-- fairly evenly across the board. The only question left on the ITC is how to pay for unused tax credits. I'm going to ask for a show of hands to see who's got -- (End side one.)

-- I don't believe in it, which is political heresy. (Inaudible.) But the reality is that people don't earn their income (inaudible) and the government takes it away from them (inaudible). That way we have income averaging and things like that. (Inaudible.) fair to assume that because somebody doesn't pay (inaudible) that they are somehow or other ripping off the -- ripping off the system. But we are of course politically (inaudible) income tax. You will see us struggling mightily with that issue.

Well, I think I have -- I've covered everything but the reasons why we're doing all of these sort of things and I won't touch on that on the assumption that what we're doing is what the American people have been waiting for us to do. And I will not quit and respond to your questions. You can ask questions on any subject. Don't hold back. (Inaudible.)

MR. HALL: Senator?

VOICE: Yes.

MR. HALL: I'm Bob Hall. I'm not from your State, but I agree with everything you say. But I don't

know why the Republicans always do this when they get into a second term. You know, I am a small business person. A lot of people in the room are. We're the traditional backbone of the Republican Party. Why they insist on turning us off. I try to run my business (inaudible) to accept the things I cannot change, courage to change the things I can, wisdom to know the difference, and, you know, you need time to make the changes you talk about. But in the meantime, why not pay the bills on time. That's something that I think any Congress person can have a powerful effect on and I wish you'd get back to your office and call the people up at HCVA and tell them that that's the message you got this morning.

VOICE: Great. Thank you very much.

Is that a general view?

VOICE: You bet. Here, here.

(Applause.)

VOICE: You were talking about the anti-regulation climate that we're in. One area where we seem to be going in the other direction (inaudible) we're allowing market forces to dictate more and more (inaudible), but HCVA is going in fact in the opposite direction. There are several things that (inaudible).

VOICE: Well, for those of you in my region -- I don't know what region that is, out of Chicago -- I went and I dropped in on the regional office Friday afternoon --

(Laughter.)

-- and they claimed that everybody wasn't there. Were out inspecting something or other.

(Laughter.)

(Inaudible) the Regional Director was advising us (inaudible) thought she was in charge of (inaudible). The regional director of HCVA was there and a substantial number of the people were there. In fact, to be honest about it, they stayed -- about 60 of them together at 4:30 and they stayed until 5:00. We had a little Q and A.

But I was sent to this (inaudible) and what they were -- because it isn't just their problem. It's the intermediaries. They didn't make excuses for late pay to the degree that they rationalized it and they gave me some examples of how (inaudible) is going to get worse in the next couple of months. They were saying that change in policy is coming too frequently and that the regulation process can't keep up with that. (Inaudible) the rationale was (inaudible). I know the difference between the two.

VOICE: The one thing that HCVA has done -- I don't' know how some of the other (inaudible), but our carrier has said that HCVA now does not allow them to open the mail to process anything for payment until it's been there for 21 working days. That's a full month.

VOICE: What state are you from?

VOICE: New York.

This is the carrier in Binghamton, New York, and this is the way that they have interpreted the slow down with (inaudible). I don't mind -- you know, if it will reduce the deficit, we can live with a 1 percent cut or a 4.5 percent cut on something. But you can't live with no cash flow.

And in my case -- I think you go back to (inaudible) and we have 62 employees, 62 families that depend on our cash flow. But 62 times 250, that's the number of voters that are being turned into more liberal Democrats right now in my own personal judgment and I don't I'm an exception in this room. That's political suicide to do things like this.

VOICE: Well, I'm afraid we've --

(Laughter.)

-- that's more than a couple of bucks and if I can't (inaudible). I don't blame you for your switch. I don't (inaudible).

VOICE: Well, just to answer his -- we're on the other side. We're on the other coast, in Northern California. And HCVA gives an answer no later than 3 o'clock in the afternoon because we're gone by 4:00. That they cannot process claims more -- this is Northern California -- Blue Shield cannot process claims more than

three hours a day because Medicare does not pay them any more money and they're cutting their funds so they can't utilize their staff any longer than that.

They get a million claims a day, so how are they going to pay? They're 60 to 90 days behind now.

VOICE: Maybe you can talk with -- pick out a few of these examples for me and maybe during the course of your stay here each of you can give an example (inaudible). That's a different kind of example. Maybe when they're saying they don't even open the mail for 21 days in Northern California the administrative (inaudible) --

VOICE: Right.

VOICE: I'm from Michigan and in Michigan Blue Cross gets processed a lot of other things in the last couple of months (inaudible)

VOICE: (Inaudible.) HVCA has come out with regulations (inaudible) take more rate setting power. A couple of different regulations, most recently the reasonable charge limitation, and the association had to make comments on the proposal. It really hit upon the point that the original legislation said that payment had to be based on local charges prevailing and customary methodology, and it said that if there is going to be a change in that it ought to come from Congress.

I'm wondering if Congress has any opinion on that

and it's concern that the agency is --

VOICE: Have they come down the line (inaudible).

VOICE: There's been a couple of different proposals, but the most recent one is the reasonable charge limitation where HCVA would have the power to set rates if it felt like the carrier (inaudible) for a number of different --

VOICE: I'm going to have to look into that. I'm sure that we can bring anything and that they can (inaudible) or do a rule. But if that is a problem -- normally we (inaudible). They can be precise enough (inaudible).

The lady behind this couple --

VOICE: I'm also from Rochester, New York.

The other message that our carrier has given us in terms of payment is that the vice president of operations of our carrier has been given a number of claims and a total hour value that they can process per month and that this has come from the regional office and the regional office has gotten (inaudible) and that they are only allowed to process X number of claims (inaudible).

The other problem that we're having is that the carrier is taking these new rules and regulations and applying them to previous claims, 1981-82-83, in post-payment reviews. I believe there's a constitutional

provision ex post facto in which you cannot take a new law and apply it to past history and that --

VOICE: I would think that (inaudible).

VOICE: The post-payment reviews are taking new rules and regulations and they're going back to claims for 1979-81-81-82 and 83. (Inaudible.)

VOICE: Okay, let me leave this part of the issue (inaudible).

(Laughter.)

VOICE: (Inaudible) for Nicaragua.

(Laughter.)

VOICE: Senator, you said briefly (inaudible) that you suggested that 39 percent (inaudible).

VOICE: Bob recommended 20. We were all for 15 because (inaudible). So I think -- I don't know where the politics are in -- we're all political animals. At some point in time there must have been (inaudible) public pressure on tax reform that might affect the outcome of this. All I can say is that I would hope because we are so queazy about (inaudible). If we -- the farther down you bring the marginal rate, the smaller will be the alternative benefit tax as well, because (inaudible) the more everybody has to do computations. Some people have three computations, depending on what they're doing (inaudible).

So I would hope that we will end up with a 15

percent rate. I doubt if we will because even to come in with a 39 percent marginal rate at the end of this mark-up process we're going to have to use the Packwood existing 20 percent to do it. We will weaken the base hopefully by taking (inaudible). Try to take it and that will cut some of the value of the (inaudible).

But I think the AMP is strictly politically (inaudible) percentage and everything else is all type of policy. The President gets all (inaudible) sometime this summer. The President starts running off those lists of companies that don't pay taxes with people who pay below the 20 percent rate and all that sort of thing, then you're going to get stuck with a higher (inaudible). You'll have one place to go. By cranking up -- cranking the base up and cranking -- you get (inaudible) in there also because to the degree that we make depreciation (inaudible) we give on the one hand and take away (inaudible) and the poor guy back there really has (inaudible) because that's the way that AMP gained and end up (inaudible)

But then for a new company, for a growing company, for a company that's in the period of investment and marketing pause and heavy investment expenses to get the company going to develop markets and all that sort of thing (inaudible) by 25 percent (inaudible). And investors in the business know that just isn't smart investment (inaudible),

even though it may look like good tax policy. It's isn't smart investment policy.

It's really hard to predict where that particular one ends up. But I think I've articulated the concerns that we on the Committee have on the spread (inaudible).

VOICE: (Inaudible.)

VOICE: The question is on the value added tax and the (inaudible).

Most European countries (inaudible) rebate the value added tax on -- so I think that is part -- I don't know whether it's part of an international (inaudible) or just practice or what (inaudible). That is one of the ways in which we keep from having -- some of us from buying -- having to pay (inaudible) having to pay for the social security (inaudible).

If I were doing it, I would phase in base broadening (inaudible) and pay for it with -- pay for it (inaudible) or I would, instead of moving rapidly on some of the depreciation, I would (inaudible) you can do (inaudible). Some of the base broadening can be done (inaudible).

Yes?

VOICE: (Inaudible.)

(End tape.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

11-12-85

Speech to

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EX. 223

SENATOR DURENBERGER: ...and then the direction that I see the federal side of particularly Medicare and Medicaid (inaudible).

The first question, I looked through the agenda here (inaudible), and you are going to get -- you are probably not going to get all the truth from all of these folks. You got some people who will tell you how the process works; in fact, probably heavy on that sort of thing, and then you are looking at HHS and HCFA at a time when I guess you couldn't do anything about your scheduling.

(Laughter.)

You step back and a couple of months from now all the faces will all be changed (inaudible).

But I guess nobody will be able to share with you the experiences that somebody has as a Senator. I spent an hour and a half this morning with the President and the House and Senate leadership, and I guess I was there because I was Chairman of the Intelligence Committee and he is going to Geneva.

But the interesting part about the hour and a half we spent together with all the Democrats over there -- the Speaker wasn't there, but Jim Wright was there and

Rostenkowski -- they made quite a thing out of how nonpartisan this trip is going to be and how important this trip is going to be, the first one since 1979, and how the old country was going to be behind the President. The President was then able to say, yes, guys, but it would be awful nice if when I went to Geneva I wasn't representing a country which has for the first time in 200 years defaulted on its obligations, which gave us an opportunity to talk about Gramm-Rudman and the budget resolution, the deficit and all that sort of thing.

The President (inaudible) to the House, you guys got to quit politicking and pass Gramm-Rudman, the debt ceiling bill, and so forth, so when I go to talk to Gorbachev I am not representing a country that can't make up its mind.

And Les Aspin said, but, Mr. President, we are really trying to save your bacon on opposing some parts of Gramm-Rudman because that -- when you get to your concerns about defense spending and you look at what Gramm-Rudman is going to do when it takes us down to a balanced budget five years from now, there is no way you are going to get any growth out of defense spending.

And the President's reply to that was, well, you are all presuming that the only thing in Gramm-Rudman is the sequestration conference. That is the end where we cut

everybody by 5 percent or 10 percent, and he said, oh, the purpose of having that in there is to make sure you never have to use it. If you use the front part of it, which is the reconciliation process, which we still have (inaudible) today, that you use that part of the process. First, budget resolution, followed by reconciliation, which sets the limits for our spending and our revenues. But you use that part of the process to bring your budget in line.

To which Paul Laxalt, sitting next to me -- and Paul wrote one word down there (inaudible), a five-letter word, starts with a T, has an x in the middle, and ends with an s, and the word is what?

VOICE: Taxes.

SENATOR DURENBERGER: Taxes. Yes, because there is no way to go from last year's debt of 200 -- deficit of $212 billion -- I mean, not last year, 1985. It is the year we just left in September. $212 billion deficit. Take that down to a $144 billion deficit in a budget resolution that we have to pass in May of next year, in six months, to go from 212 to 144 billion, still have a strong defense, still preserve Medicare and all that sort of thing unless you raise taxes.

So that is just sort of a fait accompli that we may not deal with next year -- I don't know, next year might be just a lot of bloody cutting all over the place, and it

is an election year and all that sort of thing. But realistically we are probably going to have to do something with taxes. To go from 144 and accomplish zero, there is no way it is going to be done without raising revenues.

So that is the essence, and that is what nobody will tell you about the essence of this process.

There is a war been going on between the public and their elected representatives now for 10 years over government spending (inaudible), and nobody is winning the war. There is a difference of opinion about what government's role ought to be, and we are at the point now where if you take the outright spending, the $967 billion that we spend, and divide that up into its major components, you find that most of the things the President supports has been going up -- spending has been going up, and the things he doesn't support the spending has been going down.

So he has accomplished or is accomplishing his end, which is to reduce the spending he doesn't like, and with our help, while by the same token he has been increasing his spending that he does like, and the three areas that have been increasing have been defense, social insurance, and interest on debt, where we have gone -- in defense we have gone from $145 billion to $287-288 billion this year. In his time in office we have gone -- on debt we have gone from $49 billion to a net $137 billion, and social

insurance has gone from 199 to 322.

So, you know, that is up like that. All other federal spending has stayed level funded, actually gone down in real terms because we have gotten rid of a lot of programs. We don't do a lot of things any more, and each year we get rid of some more. But the rest of it has been level funded at $200 billion all the way through.

So, you know, $200 billion in federal spending is still more than $212 billion in deficit, and so if you got rid of all the spending other than debt and social insurance and defense, you still don't balance that budget without increasing taxes.

So let's go over taxes very quickly, and the reason for the deficit obviously is that we stopped taxing people in this country on their incomes. We just -- we quit in 1981, or actually between 1981 and 1983. We reduced the -- on a very uneven base under the tax system, a base in which George Bush paid a 12.5 percent rate and I pay 45 percent, and he makes more money than I do. On that kind of a base we reduced the rates by 25 percent across the board, cut the marginal rate from 70 to 50 percent, and shortened up the useful life of property for depreciation purposes, preserved the ITC, added in a variety of other things, the net result of which the income tax has not raised an adequate amount of money this year.

This year the individual income tax will raise $331 billion against a total spending of $967 billion. About one-third of our federal spending will be covered by the income tax.

The corporate income tax this year is predicted to rise. I don't know whether it is or will, but even if it does rise, predictably it will raise about $58 billion. That is the same amount that it raised in 1977. But if you think that is an adequate way to finance government, you know, you got another think coming.

So 331 and 58 still doesn't get you up to $400 billion. What makes up the difference besides the debt? Obviously, the payroll tax. Nobody complains about the payroll tax. The payroll tax is regressive. You pay on the first dollar that you earn. Everybody pays. If your husband or wife goes to work, you pay double, and if you are under 35 years of age it is (inaudible). But nobody complains about it.

This year it is going to raise more than the income taxes, and it raises that for Social Security and Medicare and disability (inaudible). Right now it (inaudible) raising more than it needs. So we are actually (inaudible) anybody here in the $39,000 a year income bracket and pays the top rate, this year it is just $5400. In four years you will pay $8000, meaning that that is --

the price of going to work will be $8000 so my folks can live in Florida nine months out of the year and making more money than they ever made when they worked. That is the price of work, $8000.

That Social Security Trust Fund, if it were taken off the budget this year, would increase the deficit from $212 billion to $276 billion, this past year, which means that we are taking in more money than we need. But this year, the Social Security this year, the Social Security Trust Fund is $7 trillion underfunded, $7 trillion. That is for everybody who is working today, we are short $7 trillion in their life expectancy when they retire.

That is why I say that there isn't anybody under 35 who is going to collect Social Security because in order to collect Social Security if you are under 35 the payroll tax will have to be 41 percent, and nobody is going to tolerate 41 percent.

So that looks like an insoluble problem, but it is not, and here is why it is not insoluble. It is not insoluble because a good way to raise revenue in this country is to make sure that your tax system makes some sense for the people of the country, and to get off the notion that everybody wants -- doesn't want to pay taxes because taxes go to government which nobody likes.

So if I leave you with more of the message, it is

that government is not fat. It hasn't been operating very well. It has got excesses coming out of its ears, but a lot of those excesses have been bled out of the system already.

But there are still a lot of politicians going around convincing you that government is fat because none of you want to pay taxes. You are not going to volunteer to pay large amounts of taxes, and yet you in the hospital business ought to know that if we didn't pay taxes, I mean if we didn't have government in this country there is no way you could survive. You could not survive on the private market all by yourself. You can't make it because that is what hospitals have been doing up until now. They have been trying to survive in some kind of a private market, where they took in everybody that came along, and you can't do it. You just can't make it.

You can't take care of the poor and medical education and high technology and all that sort of stuff on this market without the help of government, and the only way you are going to have a healthy hospital industry is if government levies some taxes, which raises some money, which will buy the poor into your hospitals, which will buy a more realistic medical education program, and those are the kinds of responsibilities that we need to take on in government so you can stay in the hospital business and you don't have to go into the poor people business and all that sort of thing,

so you don't have to take the heat from the nonprofit competition that says in one way or another you have got -- the for-profit organization has got a leg up on the nonprofit because they don't have to take care of the poor, et cetera, et cetera, et cetera.

You all would like to take care of everybody if government responded to its obligations to access people to the health care system, those who can't afford to get into the system.

But to stay with my point, and if we ever thought good things about government, we could then think good ways to have government do things better. Let me just stick with the poor here now and the money that is available to access people to your hospitals.

The Medicaid program takes care of about 50 percent of the uninsured, indigent, whatever term you want to use, maybe less than 50 percent. All the rest are left to sink or swim on their own (inaudible) what uncomplicated care you can allow in your system is what takes care of those people because you don't turn people away. I mean, you don't dump people in the streets and that sort of thing. You may not give them Cadillac care or whatever, but goddamn it, you are not going to let people die despite what some of the House members claim for (inaudible). You don't do it (inaudible) to let that happen.

But anyway, the current systems, the current welfare system in this country spends a lot of money, $100 billion a year, is not taking care of most people who really need access to the health care system.

So one of the things we all need to do is make sure that system works better, but that isn't the only thing we need to do. Just reforming Medicaid and AFDC and food stamps isn't going to solve the problem because there is still going to be a large gap in there of people who don't have services.

I will tell you who a lot of those people are. There are farmers in my state who when they got their backs against the wall are not going to buy health insurance. That is the first thing they are going to get rid of, is their health insurance, and it is unfortunate that they do that and -- because Lee Iacocca, who I keep picking on -- this is the most visible example, because his book sells much better than mine --

(Laughter.)

Lee Iacocca gets from us tax favors. Besides getting a $2 million salary, he gets $320 a month in free health care, paid for by the taxpayers. But my farmers don't get that.

My farmers, if they are going to buy life insurance, or the guy who owns coast-to-coast hardware

stores or the shoe store or the drugstore or whatever, he or she has to buy their health insurance with after-tax dollars, and so they skimp on their employees. They get these kids that come in and work on weekends, people like that, or the farm wife who comes in and works in town so they can stay on the farm. They don't buy them adequate health insurance because they can't afford it.

But Lee Iacocca gets from you $320 -- from us taxpayers $320 a month in tax-free insurance. It doesn't have to declare it on his income tax. Chrysler gets to take a deduction. It is a $49 billion a year subsidy that we provide for part of the economy.

Well, tax policy it seems to me could make some sense if it recognized that changes in tax policy can access the farmers to the system the same way it could access Lee Iacocca to the system. I don't think Lee deserves $320 a month of health insurance coverage. I don't think anybody needs that much money because one doesn't have to spend that much to buy a decent health plan, and besides the $320 a month that is no longer health insurance (inaudible). That is just give-away. That is just -- you know, "go get sick and we will pay the bill" kind of crap, and Chrysler can tell you all they want all the wonderful things they are doing to cut down on their health bill, as they are. As long as they provide free health insurance they aren't doing

their thing.

So you could take some of that -- if we capped that part of the free give-away of health benefits (inaudible), we could use some of that money to provide deductible -- deductions on people's premiums who are self-employed or something.

Now, that is one example of what you can do with decent health policy in this country, or a decent tax policy. But in the larger sense, though -- I am going to shut up here so you can ask some questions -- in the larger sense one of our problems is we haven't really given a definition (inaudible).

Most of you think excess spending is what I do. When I get here and I have got things cut right down to the bone, so to speak, at least insofar as I can cut it down to the bone, I say the excess spending is with you. I say that Lee Iacocca, with $2 million in salary, is spending too much money when he spends $320, tax free, on his health insurance. That is a form of spending.

Also, Lee Iacocca and the rest of those guys got us to keep the Japanese automobiles off this market four and a half years ago. They spent a lot of your money.

Today every American car you buy costs you $1500 more than it should have cost you. Every Japanese car you buy costs you $2400 more. Each car, not just in the

aggregate. Each car costs you $2400 more than it should just because we kept competition out of the U.S. market.

Now, that to me is a form of spending. We saved 40,000 jobs, United Auto Worker jobs, at $23 an hour and all their free fringes, and it costs billions of dollars.

Now, out on the floor of the Senate Fritz Hollings and Strom Thurmond are doing the same thing for textile workers. They are going to raise the price of everything you buy in this country to protect their political constituencies in North Carolina, South Carolina, whatever, for their textile workers.

Now, I am voting against that, but I don't -- if they win, all I want is people to understand that that is the same kind of spending that when I go out there and I say I am for $3.03 target prices on corn, I want everybody to understand it is the same damn thing. I am saving my corn farmers outright expenditure of $3.03 in the Commodity Credit Corporation the same way Iacocca saved the automobile 40,000 Auto Worker jobs.

Well, I think I am giving people a better deal. You don't have to spend $23 an hour plus another $12 in fringe benefits for each of my farmers, and you are also guaranteed the cheapest and the best food in the world by keeping those farmers.

But the point is not to start an argument with

textiles or auto workers. The point is that there's all kinds of ways to spend money. Tax spending continues to go up (inaudible). I want to buy a new car. I just go out and borrow (inaudible). In fact, I did. I bought a secondhand car, Olds Sierra (inaudible). I borrowed -- I think the car cost $9500, something like that, and I think I borrowed about 11. It was a good excuse to borrow money.

(Laughter.)

I am going to write it all off on my taxes, and you are going to pay for my car. I have got a cash flow. I can afford to do that. But that is the same kind of spending. I am buying a new automobile every two years at your expense.

And I think if we ever would come to grips with an understanding of how we spend money in this country, either through the tax system or directly or through the restraints we put on competition (inaudible) hopefully we have beat state rate setting programs, you know, so that hospitals can genuinely compete, but go to New York, go to some of the states that have rate -- in effect, rate setting, and look at the hospitals in those kinds of states. They are a franchise arrangement. They are all public utilities. They just said we know you are inefficient, but you are all we got. So we give you a franchise so you can stay in business, and we will raise your income each year by

some predictable amount so you can stay in business.

You have the same -- that is just like the automobiles and the textile workers and everybody else, the nurses unions, whoever else might come along. They want to bargain for more money in their hospitals; they just go ahead and do it. And in New York State you have been given a franchise to add to the cost of health care every year because each of those hospitals can't die because we need them all.

So that same sort of thing goes on in your industry (inaudible). So if we could -- as a society we could start to think about spending in those terms, I think we could deal with each of those individual elements much better, but on tax policy you don't have that option. The tax policy option today is simply are you for a flat rate tax or not.

Let me just ask (inaudible) a flat rate tax (inaudible)?

Okay. Let me suggest one of the reasons why you might like it, (inaudible) we will get into a discussion of it, but there is the notion that if we eliminated all these darn tax expenditures -- you know, 300, almost $400 billion in income tax alone that doesn't come in because I keep charging you for my car, that sort of a thing, or George Bush charges you because -- the reason he has got the 12.5

percent rate is that he bought into an apartment building -- or a commercial office building in Houston, which Houston of course doesn't need any more commercial office buildings. We got a big tax shelter that is going belly up.

(Laughter.)

But if we got rid of all those things, you know just put the system in neutral, we could really bring the rates down substantially. Now, I have to ask you before you can raise your hands to think about this.

We already have some systems that work like that. At the local level your property tax works that way. I mean, it doesn't make any difference whether you have got kids in school or not or, you know, any of that sort of thing. You pay X number of dollars, a percentage of the value of the home.

The same thing is true of the sales tax. You know, you got a sales tax. Everybody who walks into the grocery (inaudible) or buys a television set or a car, whatever, pays a sales tax.

It is only when you come to income, so that you can have a tax system that is somewhat progressive in terms of ability to pay, and let me just ask you these questions.

If you were taxing -- if you were going to tax income as an alternative to the notion of a flat tax, if you thought about it in terms of the money, you know, why people

earn income -- why do all you people in the room have jobs, try to earn incomes, and so forth -- the first reason you do is to provide for your basic needs and those of your family, shelter over your head and food on the table, health care for your kids, all that sort of thing. Well, government is going to tax your income. There is an opportunity for government to think in terms of how will that tax impact on my purchase of a home. Right now we say housing you get for free. You know, borrow the money. We give it to you as a tax deduction. So it is a free commodity, meaning nobody cares how much it costs other than as it relates to your cash flow, and even though nobody cared until just recently when we discovered that 93 percent of the people are priced out of the market without a further subsidy.

But that is the first question you ask. The second question you ask about why people work or earn an income is, isn't it true that a lot of people want to save for a rainy day?

I think that is true. I think that is why a lot of people work, because they know that there are periods of time when they can't work. They used to put it in a Mason jar under the floor of the kitchen somewhere, pull it out when they needed a couple of nickels, because dad was sick and couldn't work, and so forth.

That is the second reason that you earn income,

and so when government decides to tax your income, don't you think government should consider the impact of that tax on your income.

The third thing that you do is provide other people with investment capital or yourself with investment capital. When we tax income, we have to consider the impact that that has on your willingness to invest in enterprise in this country.

The fourth thing you do with it is provide for your schools and your police and your fire, and all that stuff that goes on at the local level. So for every dollar that you spend on local -- state or local taxes, shouldn't we at the federal level consider the impact that taxing your income would have on your willingness to do that?

And the fifth thing of course is consumption, and right now the way the tax system works there is an absolute incentive to consumption; whereas, everybody would rather do something else.

So those are five questions that I would raise about an income tax if I bought the first notion, which is that it ought to be progressive because the others are flat.

Now, those of you who raise your hand might say, you know, if we all had a 35 percent rate or a 30 percent rate or some rate like that, it doesn't have to be progressive just so long as we exempt the people on the

bottom. Now, that is legitimate thinking, and I am thinking (inaudible) I am just trying to show that there is another way to look at income tax which nobody is looking at today, and so what I want to say for those of you who think a flat rate tax is good and we ought to get it down as low as possible, I want to say Ronald Reagan is on your side. He agrees with that.

But then I don't want you coming to me getting me to save the investment tax credit or return on equity or ACRS or the interest deduction or any of those sort of things and don't ask me to be Solomon and sort of phase this thing in slowly and gently.

I am much more comfortable operating off those five principles than I would off a flat rate tax, only because I hate deficits, and that brings me to the end of my speech, which is an appeal to all of you to consider with me and the people in my generation the fact that we are about to be the first generation to leave our children less well off than we were left, and everywhere I turn I find big problems (inaudible), huge problems.

Just last year's deficit, $212 billion, will cost my four sons $10,000 in taxes each. The existence of the deficit means that I can't tackle acid rain and toxic waste and groundwater problems and a whole lot of other things. I can't have a national -- make a national contribution to

indigent care for the poor because I haven't got any money. Social Security already isn't going to be there for people 35 and under.

I worry a lot about people 35 and under and what my generation is laying on them because we insist upon having today without paying for it, and I hope that you can put enough pressure on me and my colleagues that we as a society can get out of this notion that we can have anything we want without paying for it.

That isn't just -- I am not making a sell here for taxes (inaudible), but I think in general we all -- somehow we have to learn to live within our means and that there isn't anything free in life, and that starts with health care.

I mean, my generation was raised to believe it is better to be sick than it is to stay healthy, and you want to know why the cost of health care is high in this country? It isn't the hospitals, and it isn't the doctors. It is me and the notion I can smoke myself to death and you will rescue me with an artificial heart. I can drive a car without a seat belt, and you will cure me with no cost to me, or a motorcycle without a helmet (inaudible). That is what my generation has been taught to believe, and it is a big job for you younger folks to convince me that that ain't the way it ought to be, but you better start now or there

isn't going to be (inaudible) when I get to Social Security age in about 15 years.

Thank you very much (inaudible).

(Applause.)

Yep.

VOICE: Most of the speakers we have heard left me with pretty much a pessimistic attitude about, right now, the whole government process.

What can you do to really affect anything? Either we as citizens or yourself as elected representatives. What I see on a very local level is government can't do anything until there is a heck of a crisis.

Do you agree with that and what is the crisis going to be and who is going to recognize it?

SENATOR DURENBERGER: It is. You are going to be very pessimistic and I am going to (inaudible), but I have tried to share with you today a couple of thoughts about where you ought to be.

I mean, when Ronald Reagan or anybody else gets up and says, you know, (inaudible), baby, all we got to do is hold him, you know, don't spend a nickel in taxes and all that sort of thing, you got to say, hey, wait a minute, it is much more complicated than that, Mr. President, and you have got to be like Paul Laxalt. You know, you have got to

write -- sometimes you do have to write "taxes" on a little memo pad and say this is the only way out of this thing, deficit (inaudible).

But in large part I think you have to think -- you have to think positively (inaudible). You have to think about the things that we are not thinking about, like living within your means. You know, to us that just means balancing spending and revenues. To us as a society it has got to mean something much larger than that.

It has to mean things like (inaudible) somehow we have to bring the price of housing down in this country. I don't know how, but we have got to bring it down. We have to bring it down.

And I have got two homes now that I paid a total of $500 for. I got one in McLean that is worth about $350,000 and one out in.....

(End tape.)

(Whereupon, the speech was concluded.)

VOLUME XI

EXHIBITS 224–234

TRANSCRIPT OF PROCEEDINGS

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CLINICAL CONFERENCE

Durenberger, Dave (Senator):

"Liability: Medicine: Government"

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EX. 224

SPEAKER: I am going to make a brief announcement about the coming programs, before turning the podium over to Dr. Windham, who will make a further announcement and introduce our distinguished speaker.

First, I'd like to make one announcement, as a matter of order -- and I'll remind you of this later, because I see that the holiday crowd is not as heavy as the other crowds, and I want this message to get through. We are having some problems in the doctors' parking lot on Friday mornings. This is because some of our physicians who are not on the staff who have retired are using that lot for these conferences, and it makes it very tough for the guys who are arriving to find a place and park.

So we would suggest, please, if you can use the enclosed parking area it would be very helpful to us on Friday morning. The people in charge of the gate sometimes don't know who is on staff and who is not, and I'm sure you're not aware of the problem that's being created. So we

would appreciate it.

Incidentally, next week I won't be here. I'm going to get that little dive trip that I missed last fall. Dr. Charles Matthews, who often covers, is taking off on a trip of a similar nature -- but perhaps more legitimate. Dr. Vanderpolar is going to introduce the speaker and monitor the program for me, and I appreciate that. Dr. Richard Goldstein will be our speaker next Friday. He is assistant professor of medicine at the University of Texas Science and Health Center, and he's going to talk to us about inatropic agents, the other side of the coin, the treatment of heart failure.

The following week, we're going to have an interesting program. Dana Shires, who you all know or remember I suspect, who is the chief of nephrology at the University of South Florida, is going to talk to us about the transplant program in this area, something we have heard about before, several years ago, but which we need to be updated on, and recent events have pointed out to us in this community how very important that is and what possibilities may arise.

Dr. Windham has another announcement to make, and following that he will introduce our guest speaker, and I'll go sit down. See you in a couple of weeks.

DR. WINDHAM: Our speaker I'll announce in a

moment. First of all, I want to announce a program is going to be held here on Saturday afternoon, December 14th, two weeks from tomorrow. The reason I'm announcing it to you is that possibly you'll be able to talk to some people who might be interested in coming.

The program is going to be geared like this. We'll have an audience participation, and we're going to have four physicians on the lower level here, who are going to speak on heart disease. Cardiac surgeons Don Snyder and Tom Kelly, and then we're going to have Doctors Meyers and Hartmann. So we have four, two cardiologists and two heart surgeons, talking about heart disease and responding to questions from the audience.

It's going to be somewhat similar to a "Donohue" type show. And we hope that we'll get enough participation from the audience to possibly continue this show. It will be televised, at 1:30 p.m. on the 14th of December. So if you know of anybody interested in heart disease who wants to participate in this manner, please let him know about it. Because there will be other publicity and notice in the paper and elsewhere.

Our speaker today was here a year ago, and many of you heard his presentation, so he really does not need a great deal of reintroduction. He is probably the number one, leading representative we have in Washington in our

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elected government, and particularly in the Senate, in the area of health.

Senator Durenberger in his years in Minnesota was active in the state government. At the time he was a candidate for governor, it became obvious or apparent that Mrs. Humphrey was leaving the seat as senator from Minnesota. He ran for that seat, and was elected with a very significant plurality.

He served the rest of her term, for four years, and then was recently re-elected when he ran for a six-year term two years ago, or last year. And so he won that race very handily, and the people in Minnesota are proud of what he's doing for them, and we are certainly proud of how he represents us throughout the country.

But particularly in the area of health, Senator Durenberger has really been concerned about health policy, and also the changes going on in health regulation and legislation today.

I heard a comment the other night about how certain things work in Washington. If you're dealing with something that's moving, they tax it. If it continues to move, they regulate it. If it stops moving, they subsidize it.

So I hope that in the area of medicine we can continue to move along. We've been taxed, we've been

regulated, I hope we don't stop. If we do, maybe we'll get some subsidy.

But anyway, he's going to talk to us today in the area somewhat related to liability. Dr. Bishberk tells us that we have to meet five hours a year of risk management type of programs here, and risk management relates to liability, liability relates to government involvement, and that in turn relates to medicine and health. So he probably will touch on that subject, we'll call it as a risk management program in that regard.

So let me welcome our annual Thanksgiving Day turkey from Washington --

(LAUGHTER)

DR. WINDHAM: -- Senator Dave Durenberger.

(APPLAUSE)

ADDRESS OF THE HONORABLE DAVID DURENBERGER
UNITED STATES SENATOR FROM THE
STATE OF MINNESOTA

SENATOR DURENBERGER: I hope you all got that line.

Bob, thank you very much. You should have given George Bush credit for that: "tax it, regulate it, and if it stops moving subsidize it." That's George's line, and he

may get elected President of the United States on that line.

Well, I am here from the government, and I'm just here to help. This is my annual trip. You probably are subjected to your local senators and congressmen when I'm not around.

I am reminded of how difficult it is to speak to a group that you don't directly represent. I used to think that I could be real honest when I got away from home, because you couldn't vote for me. But then, as things have been getting more and more difficult for people to understand in Washington, and the economy and a lot of things lately, I've discovered that even when I go home I am honest. And that is coming as a sort of a surprise.

I don't know whether my constituents have caught on to that yet. But I was reading an article in the Worthington, Minnesota "Globe" the other day, and I was in Worthington, Minnesota, oh, about a month ago now. And Worthington was one of those boom cities, where 50 new businesses came into this little town and made it a fairly large town every year, until the last two years. And it's right in the heart of farming country, between Iowa and Minnesota and South Dakota.

In the last year, it's lost 30 businesses, alone. And it's just going right down like that. And so, with everybody in town panicking over what's happening to

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agriculture and so forth, I went to town and met with a couple hundred people and said, "For once, I am here without any answer." I don't have any money, I am $2 trillion in debt, I have accumulated a $212 billion deficit add-on to that debt just in the last year. So I don't have any money. I also don't have any answers to your problem.

"Four years ago, you went out and bought land out here for $3,560 to $3,575 an acre. Today, you can't sell that land for $600 an acre. And you're wondering, 'What in the world is happening, and who is going to do something about it?' And everybody faces east, towards Washington, D.C., expecting that somehow the answers are going to be there."

And I said, "The reality is, I don't have any answers for you. And also, I'm going to tell you that, because the time has come for politicians to be more honest than their constituents would like them to be."

Now, I didn't know I said that: "The time has come for politicians to be more honest than their constituents expect them to be," until I saw that in the Worthington "Globe." And I'm very impressed with that statement.

(LAUGHTER)

SENATOR DURENBERGER: And I sort of hope it gets to be contagious. I hope it catches on all over the place.

So this morning, I am going to be as honest as I can be, and I trust that when I finish a few comments here on the subject that I was assigned to speak on, that you will be honest as you were a year ago in your reactions to what I have to say, and that we can perhaps in the question-and-answer period cover some of the subjects in health policy that I won't cover in these remarks.

For example, Bob took me through the medical records section, and I saw all these signs that said, "There doesn't have to be a reason, it's PRO policy." And I'm sensitive to that, because I'm the guy that created the peer review organizations. I did not take down the signs. But I probably will welcome the exposure to some questions or some comments by all of you to how the peer review process is working.

Well, let me start with subsidized -- if it moves, tax it, if it slows down, regulate it, or if it still moves regulate, and if it stops, subsidize it. Let me flip that around, so that I can get into the subject of risk management. This will surprise Bob, because I'm sure he put that on there only because that's the subject for this series of required seminars. But I want to end up with a couple of 21-year-old thoughts about how, maybe, we as a society ought to address the subject of hospital and professional malpractice.

Let me begin in 1934, which is the year that I was born. '34 is the year that my parents had me, because I was about all they could afford to have.

(LAUGHTER)

SENATOR DURENBERGER: And it was really tough, as some of you know, in the depression. My parents swore, my parents' generation, in effect, swore that I should never have to live through what they lived through in the '30s. So when they came to political power, with the Hubert Humphreys and people like that after the war, the Dwight Eisenhowers and others, they created a system to ensure that I would never really have to worry about having. They created having without paying for it.

They created everything from the $500 home that's worth several hundred-thousand dollars, to free health care. So even when things were moving, we chose to subsidize them, as a way to ensure our, what became a right to have.

By way of illustration, in housing, I own two homes today, one worth about $350,000 in MacLean, Virginia that I paid $187,000 for when I was elected seven years ago. It's now worth $350,000. I didn't do much to it, other than paint it a couple of times. And I own another $60,000 condominium in downtown Minneapolis. And those two homes were purchased back in 1960, in effect, when I bought my first home for $500 down, 30 years to pay, 4-1/2 percent

interest rate. That's how I bought those two homes; never had to make any additional investment other than that first $500 back in 1960.

Because about the late 1950s and 1960s, when my parents' generation created having without paying for it, they said the way to have housing is to make it no-cost housing. So if all you have is a $500 bill, you can have a home.

So about the time I was buying my first home, there were millions of people like me, all over the country, standing around waving our $500 bill saying, "We'd like a home." In fact, there were more of us waving our $500 bills than there were homes. So what happened to the price of existing homes? The guy that had a home to sell -- (Laughs) -- just waited until the demand got to the point where his $10,000 home became a $15,000 home.

My first home was $10,000. I turned it around in a couple of years for $20,000. My next one I turned around in three or four years for $50,000. And now, I'm up to two homes worth $410,000 between them.

And we did it by guaranteeing access to housing, by subsidizing that access through the banking system, through tax policy, the deductions on interest rates and real estate taxes, and all that sort of thing. And we did it principally, as you know, through what happens when you

have demand exceeding supply. Prices go up, inflation becomes a part of our way of life. And even though we don't like it, even though we think we should be living within our means, we give up, we give up to inflation, because we'd rather have, than fight it.

So that happened in housing, and of course it happened in health care, as many of you are well aware. We created a national health insurance system in this country in which most people were guaranteed the right to free health care. We started with the employers, with first dollar coverage in many cases for health insurance bought in the work place.

In 1954, we took the tax code and turned that tax code around and said, "This tax code in this country is going to be used for having." We created a wide set of deductions and exemptions and whatever, to make sure that we could afford to have without really paying for it in this country. And one of the "haves" was health insurance.

If you go to work for somebody and they buy you a health insurance policy, the employer gets the deduction, and it's not income to you. So you get something you might not buy with cash, because the government believes that it is a worthy commodity.

So we took that from 1954 on, and we expanded health insurance all over the country, because it was a free

commodity. In 1965, we said, "If it's good for employed people, it ought to be good for the elderly, the disabled, and the poor." So we created Medicare and Medicaid. And we did the same thing with Medicare and Medicaid; we said, "Here is your health insurance. Go and consume."

And the unfortunate thing that we did was, having protected the employed population from the costs of their bad health by having somebody else pay for their health coverage, we did the same thing with the elderly. Rather than have them pay for their coverage, we used a tax system on working people to pay for Medicare. We eventually had a system in which nobody paid for their consequences of their health failures.

And so, is it any wonder then that my generation has been raised to believe that it is better to be sick than it is to stay healthy? Is it any wonder that my generation believes that it is entitled to doctors, hospitals, and the highest caliber, quality, the latest technology. My generation believes that it is entitled to be able to smoke and have an artificial heart or longer life. My generation believes that it has a right to drive an automobile without a safety restraint, and then a right to have somebody repair whatever the consequences are.

My generation believes that you can't force me to wear a helmet when I ride a motorcycle. And then, I don't

have any responsibility when I mash my brain. My generation has been taught that to come to a beautiful place like this, be cared for by beautiful people, should cost nothing. This is the place to be.

Compared to staying healthy, there are no rewards for my generation in staying healthy. If you stay healthy and you stay at work, you've got to work. You get sick, you get time off to go to the hospital, and people will pay you for it. Nobody sends you cards or flowers when you stay at work, only when you go to the hospital. That's my generation, and that's the consequence, largely, of my parents' desire to give me an opportunity to have without paying for it.

The health insurance programs, then, that were developed, the health plans and so forth that were developed by my generation or for my generation, covered acute care, they didn't cover health care. Because they were designed to take care of the consequences of a lack of health. They covered the hospital, they covered the doctor, they covered the broken bones and all that sort of thing; but they did not cover physical examinations, they did not cover immunization, they did not cover wellness programs. They didn't cover any of that sort of thing.

Sooner or later, they really weren't health insurance at all, because everything was relatively free, so

you couldn't call it insurance. I mean, it's just something I got handed when I went to work, or my Medicare policy when I retired, or whatever, and it wasn't insurance any more. Insurance is supposed to protect people against the financial consequences that they can't take care of from their own pocket. But we loaded people up with health plans that you couldn't call health insurance any more.

We used -- what did we do to finance the system? Well, we used group rating, community rating, to spread the risk. We had the healthy pay for the sick. And the healthy and the sick all paid the same premium. We had the young pay for the old. And we had the careful pay for the careless and the negligent. And we did that so that we could all afford to have this kind of coverage.

We also created a system in which the more you used the system, the more we paid you. The more time you spent in the hospital, the more society provided you with the financial wherewithal to spend more time in the hospital. The more services that you utilized, the more financial benefit you received.

And so, is it any wonder that the health care providers in this country got rewarded much the same way? I mean, before we started into this little health care revolution, there was no incentive for doctors to practice what we call "conservative medicine," no incentives,

financial incentives; any more than there were financial incentives for me to stay healthy.

There were no financial incentives for medical professionals to practice conservative medicine. When the bypass came along -- you know, if there's any indication that there ought to be a bypass, give him a bypass. Tonsils came out like that. Hysterectomies were performed, according to all the statistics, on millions of American women that didn't need them.

But it wasn't just because the incentives weren't there; it was also because of the growing consequences of the failure, or alleged failure, of the medical profession and the hospitals in this country to keep up with this rising standard of expectations that all of us had for all of you.

Because, as we whetted our appetite to have, you gave us an opportunity to have even more. I mean, we wrote a blank check on medical technology. We wrote a blank check on surgical specialties and sub-specialties. We wrote a blank check on -- whatever, as a society.

Now, we complain about surplus of doctors, and too many sub-specialties, and a lot of things like that; but it isn't the fault of the medical profession (Inaudible). Those of us who want to have the very best, as measured not by what an individual professional can do for us -- for

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example, "Oh, come on, don't take your tonsils out, you don't really have to have them out" -- but measured by the degree, the infinite degree of specialization that is applied to a particular situation.

We created a situation in which there were no rewards for careful, cognitive, medical practice. There are really no economic differences between physicians in a certain specialty area, between those who were the conservative practicers of medicine, those who were really the cream at the top of their specialty in a community, and the people that weren't.

We created a situation in which there was no way for a hospital medical staff to withhold privileges from a doctor whose practice was less than the community standard; because the law would protect every physician. He had a right to practice in the hospital, and you couldn't deny him that right.

We're dealing with that one now in terms of PPO's and some of this sort of thing. Can physicians sort of group up those of their colleagues that they believe practice the highest quality health care? But the way we were building this situation in this society, we didn't put in any rewards for that sort of thing. Everybody billed for cost, and third-party payers paid it.

Now, liability insurance, professional liability

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insurance, operates much like the rest of the system, operates much like community rating or group rating for health insurance. It treats everybody alike, everybody alike. No distinction between the quality professional and a professional whose record shows that he is less than the community standard.

I couldn't really believe that was the case, so I went to one of my favorite constituents, the Saint Paul Companies, who write a lot of medical malpractice insurance. And I said, "Explain to me how you do it." And they said, "Well, it's very simple, Senator. We just take all of the primary care physicians in a particular area, and we in effect rate them on last year's experience, how many claims they had, how many dollars got paid out, and all that sort of thing. And then, we fix a rate for a primary care physician. Then, we have seven other categories, building up to the eighth category, which is the neurosurgeon." And I suppose seven is obstetrics now, or something like that.

But they take these specialties. And the next one up from family practice is given a rate which is twice the -- excuse me, the primary care physician -- the next one up is twice the primary care. The next one up is three times. And the neurosurgeon, all neurosurgeons in a community are charged eight times the rate for the primary care physician in that community.

And I said, "Oh, come on, now. You don't really mean that, do you? You mean that down there at the primary care level, your first level, a physician who has never had an experience with a claim pays the same fee as the physician that's had a variety of experiences, including judgments against him?" "You bet."

Up there on the eighth level, the neurosurgeons, the best neurosurgeon in the country pays approximately the same rate as a colleague who is much below that standard in that particular community. "You bet." I said, "Well, how in the world, how are you going to encourage people in that profession to practice the kind of medicine I would expect them to practice, when you charge them all the same rate, and you let what's going on down at this level multiply by factors of two, three, four, five, six, seven, and eight, all the way up the line? Where is the distinction? Where is the recognized distinction within the profession between a quality practice and one that is less than what might be accepted?"

They said to me, "Well, we can't do anything about that." I said, "Well, I believe that, you know. You can't do anything about smoking either. You're afraid to ask people whether they smoke or not, because you don't want them to go buy somebody else's insurance policy. You're afraid to ask questions about safety restraints in

automobiles, and alcoholism, and a lot of other things, in factoring out health insurance; aren't you?" And that's true of the insurance industry.

They don't build lifestyle into the premiums that I should pay. So why should they build your experience into your malpractice? Well, from their standpoint, that may be the easiest thing to do. From your standpoint and from mine as a consumer, I think it verges on fraud.

So the question gets us to, what in the world are we going to be able to do about all of this? And the best part is trying to understand -- and that's why I'm going through this background -- understand how we got into it, in order to help us understand how we're going to get out of it. Because in this generation of having without paying for it, with cost as no object, a lot of good as come. A lot of good has come from that.

There's constant improvement in professional skills, constant improvement in medical technology, and a constant improvement in the outcomes of the application of those skills and that technology. And all of that for me, the consumer, is a good. But it also presents me with a problem, because professional liability standards have increased substantially with these advances in achievable outcomes. The more we can achieve, the higher the standard that we set for everyone, and that is often difficult to

keep up with, particularly when you're going into a courtroom and trying to deal with whose standard is applicable.

It presents us with another problem. I spent all day Tuesday of this week up in Hillsborough County, looking at a ridiculous situation where Medicaid will pay $62 for antepartum or prenatal health care, which really doesn't buy anything, but they'll pay $550 a day for a delivery at Tampa General Hospital. I went to a couple of clinics that were trying to do prenatal health care.

The point I'm getting to is that one of our great achievements in medical technology has been that we can save the lives of youngsters, and we can deliver a fetus at 750 grams and bring into life someone who is so small that we can marvel at the application of our technology to human life. And if we didn't have a cost problem, we could also find ourselves marveling at the wonderful things we can do to keep people like that alive.

But the reality is that technology applied to premature births has given us an incredible number of low birth weight babies. It has also given us, on the average, four to five times as many neonatal intensive care beds in this country as in some countries in Europe in particular, where they do practice prenatal health care. And it has given us malpractice rates that are putting obstetricians

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out of business. And I can't believe that that's good for society.

Now, it strikes me that a small investment in the womb, or the mother in whose womb that child might be carried to term, would help all of us in a lot of ways. But we spend so much money on the acute care system, and inflation keeps running it through the roof, that we say we don't have the money to spend on prenatal health care. And let me tell you, in Hillsborough County, they aren't spending it. And I think it's because they think they don't have it.

They have $1,100 for a normal delivery at Tampa General Hospital, but they've only got $62 for helping that mother in the nine months before she gets to that hospital. Now, I don't want to fault Hillsborough County, because I think I ought to be faulting society in general for some of those problems.

The objectives that I think we ought to be trying to achieve with regard to risk management, professional liability, and so forth, are not just "what do we do to the lawyers?" not just "how do we structure ourselves to handle these claims better?"; but to try to look at how some of these situations arise.

And you and I, the politicians and the professionals, have a joint obligation to remind society

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that wellness and prevention and health education and all of those things are the more important part of health, the definition of health in America, than what you do once somebody arrives in this hospital.

And my objective as a senator is to try to enable you as the professionals to really become health practitioners, in the larger sense, so that you just aren't cleaning up after my mistakes; that you can provide me with the opportunity to stay healthy all my life, and maybe I never see you in this place.

And that I think is a real challenge to my generation, to try to come up with that kind of a situation. That is the objective of the changes that we are making in the payment systems in health care, moving from cost-based reimbursements to prospective payment systems. That is why we are pressing cost sharing into Medicare, into employer-based health plans.

People have to be aware of the consequences of what they do. They have to be aware that each of us as an individual is responsible, at least in part, for the outcomes of our health failures. Because until you can have that kind of a consumer, that kind of a patient, there aren't going to be any rewards for you in trying to keep people healthy and trying to get them to practice the kind of lifestyles that we know that they all ought to practice.

I mentioned that I was going to share with you some thoughts on an alternative way to approach the malpractice situation. Somebody a couple of weeks ago gave me an article -- believe it or not -- I'll just quote from it. It says:

> "Suits for medical malpractice have come to endanger the functioning of medical care and legal process. While producing intolerable economic and emotional strain for all parties, they benefit no one. These two great professions, with the imaginative help of the insurance industry, must give us new answers."

That was written in 1964, believe it or not, 1964.

The suggestion here, from a professor at the University of California in Berkeley, is that we move from the current system of liability insurance, where you sue everybody in sight -- the doctors, the nurses, the hospital, everybody you can find -- you sue them all for negligence, or criminal negligence, or whatever, under a variety of liability policies of the nature I just described to you, as far as doctors are concerned; and substitute for that a hospital accident insurance, modeled on the accident insurance that we acquire relative to our automobiles, a lot of other things.

The proposal here is that every hospital, as a

condition of its license to operate, would have to carry minimum hospital accident insurance for the benefit of its patients. Additional coverage of the same type -- that is, accident insurance -- would be made available to every patient on an optional basis.

The insurance would enable the patient injured by a hospital accident -- and I don't mean slip and fall on slippery floors, I mean what happens in surgery, or the two million infections, allegedly, that people contracted in hospitals last year -- for failure in the process of its treatment relating to services which were rendered or should have been rendered, to claim the benefits of a policy without having to identify any specific injurer or a causative negligence, and without having to take into account the benefits derived from other insurance.

The operation of the accident insurance plan would be somewhat similar to the operation of indemnity plans that are set up, for example, in workers' compensation and others, where there would be a specific set of benefits for a specific kind of an injury.

There would also be a specific award for loss of earnings or earning power, much as we have in those policies as well. And it would be on a week-by-week, or month-by-month basis. It would not be a lump sum, and we don't know how long people live. There would be provisions for partial

disability, and for total permanent disability, built into those policies, in much the way that they are currently built into other kinds of accident policies.

Now, that is just a thought. I'm not saying that that's the way we ought to change the system. But at least it is a 21-year-old idea that nobody took seriously, because we didn't have to take it seriously until we got to the stage in our development here recently when we are starting to lose professionals from the practice of medicine because of the high cost of medical malpractice.

That is a cost that those of you who are good at what you do should not have to bear, because it is a cost that is originated by my generation's desire to have everything without paying for it.

I thank you for the opportunity, again, to be here. And as I say, we haven't covered changes in physician reimbursement that are on the horizon for Medicare, we haven't covered what's going to happen to capital pass-through for institutions like this. We haven't covered a lot of other -- out-patient surgery, or any other kinds of issues that you might want to address. But that's a close to risk management as the turkey could get this year.

So I would now be happy to respond to -- is it appropriate to do that now? Go to questions and answers? Okay.

Yes, sir?

PARTICIPANT: One question. If we can't afford our own insurance policies, how are the individual (Inaudible) going to (Inaudible)?

SENATOR DURENBERGER: Well, under the plan that I just outlined, the medical malpractice -- if in fact the country established the accident insurance notion as covering you when you're practicing in this institution, then your rates on professional liability would come down substantially.

It would help also because, in terms of premiums, because such a small part of the claims that are made against physicians in particular ever reach a verdict in a courtroom. Something like 85 or 88 percent of them get settled somewhere along the line before they ever get to a courtroom.

The interesting thing is that two-thirds of the cases that are tried end up in verdicts for the defendant, not for the plaintiff. So one of the theses put forward for this accident proposal is that more people who have legitimate claims would have those claims satisfied. Because right now, a lot of people are scared off by the lawyers and the process, and all that sort of thing. More people would actually be able to have their alleged claims litigated, but for more realistic dollars.

You wouldn't be getting these $5 million verdicts for people that are 88 years of age, or 86 years of age, in terms of loss of earning power or something like that, because you'd have a fixed schedule of reimbursement.

Yes, sir?

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Well, there are societies in which the plaintiff who brings a lawsuit would have to pay the expenses in the case that the defendant won. I am not sure which ones they are, but I am somewhat aware of them.

In our society, that happens only in selective situations. And the reason why, I guess, we don't build liability for attorneys' fees into the system for the loser is that we don't want to discourage people from using the legal system.

Now, the problem comes when they use it illegitimately, when they're using it as nuisance, when they're using it as harassment, when somebody who can afford a lawyer or a lawyer who can afford to be a nuisance uses the system against an innocent party. And there again, the law has built in provisions where attorneys' fees can be assessed by the judge in the case of a suit that is what we call a frivolous lawsuit.

But in actuality, if you went to a system which

was accident insurance based, rather than based on the traditional negligence theories, I don't think that would be come a problem, the business of the attorneys' fees, because people normally in the front part of that process don't have to be represented by lawyers. It's only if they get into the appeal stage.

So I guess there are a lot of people that think we ought to go to your notion of assessing attorneys' fees, but we haven't found the right way to accomplish that yet.

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Yes, you would have to, but you would have to prove in effect a failure in the outcome. Obviously, people -- the only thing that would be different is, you don't have to pin the negligence to a specific person, but you have to be able to prove an outcome. I can't just bring a suit against this hospital without any evidence; I need the evidence of a failure of an expected outcome, but I don't have to prove that the hospital was negligent, or a particular individual was negligent. That's right.

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Well, after we -- this is the first time, as I indicated -- I just heard about this. After I expose this a few more times, I may enter it as a bill or something like that. I think that we could do a

national legislation that would convert the system from a negligence-based system to an accident-based system, without changing the traditional role of federal and state government in the insurance business.

It would mean that, state by state, the states would regulate the accident, the hospital accident insurance, or whatever you might call it. They'll determine who can write what kind of policies with what kind of coverage. What we would be doing at the national level is flipping this thing over from negligence to accident. I don't think you could permit that sort of thing to happen or to go on a state-by-state basis.

But what we've all been searching for, those of us who care a lot about the consequences of malpractice -- and there's other professions; now everybody's getting socked with this -- we've been searching for a national answer that doesn't interfere with the state role, and this just may be it.

Yes, ma'am?

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Well, I don't know. I mean, I just -- I don't know what we do about the -- if the physician's alleged failure occurs in the hospital setting, he's covered by the hospital accident policy. And if it occurs somewhere else, that's something I'm not that

familiar with.

I mean, I have had to much time to spend on doing the other things, I really haven't been able to get into that area. I put in the Henson Moore - Dick Gephardt no-fault insurance bill for a physician. I have not signed on to the AMA's bill which Orrin Hatch put in. So I don't know where that leaves -- that leaves the physician with the traditional choice between what they have now, or a no-fault system, or the AMA sort of modified no-fault system.

Yes?

PARTICIPANT: It seems to me that the no-fault system may in fact continue to raise the expectations of your and following generations, because we all know that all outcomes are not good, when you're dealing with people who are acutely ill, who are chronically ill, who have many other contributing illnesses. The risk in certain operative procedures is very significant.

And I gather from what you say that people who don't get a good outcome, when the expected outcome isn't always good, are still going to be paid. And that means in every case we've got to have a good outcome, no matter how well we do. I just -- I can see all kinds of possibilities for raised expectations and raised costs.

SENATOR DURENBERGER: Yes. Well, you're going to have that problem regardless. The anticipated outcome, that

exists in all of these systems. That exists in the current system. And you're right, I don't know how we're going to overcome that, other than slowly, the changes that are occurring -- and it's obviously very slow -- the changes that are coming about as we look prospectively at certain procedures, as opposed to the old cost-based system.

I think somewhere in there may come the answer to everybody expecting a perfect outcome, and everybody realizing that 90 percent is the best you can do, or 80 percent is the best you can do. And if you happen to be in the 20 percent, for a variety of reasons --

PARTICIPANT: You don't get paid? If it's statistically in that area?

SENATOR DURENBERGER: That's right. That's right.

PARTICIPANT: Because otherwise, I can see some patients' families extremely delighted with a bad outcome, and anxiously and eagerly looking for the worst possible surgeon.

SENATOR DURENBERGER: Right. Right.

Yes, somebody back here had a question.

PARTICIPANT: (Question Inaudible)

SENATOR DURENBERGER: Yes. The fee freeze on Part B came in last year, as a way to cut into the deficit a little bit. It was reinstituted this year, unfortunately,

because this was the year of the freeze, fiscal 1986 was the year of the freeze.

On the Senate side, we proposed to freeze all adjustments across-the-board, including the social security COLAs, and the whole schmeer. So Part B got incorporated into that, so we in effect extended the Part B freeze by another year on both the Senate side and the House side.

One of the modifications that we tried to make on the Senate side was to enable physicians to become participating, if they had been non-participating last year, to enable them to take assignment or become participating physicians this year, so that they could at least reap some of the benefit of getting themselves out from under the freeze.

Now, I don't know where that is going to end up, because the whole notion of Gramm-Rudman-Hollings, this process that we're going to decide next week and that will go into effect by the end of December for the current fiscal year that we are in, is all premised on the notion that all adjustments upward are subject to being downwardly adjusted.

So I guess my message to you on the subject of the federal budget deficit is that physicians and hospitals are in potential trouble; that those of us who have initiated this reform movement on prospective had promised that we would in effect pay in order to save money; that if

everybody cooperated in this process of turning the system around, we weren't going to use it to penalize people financially.

I am less than sanguine about the future. If we can't raise some taxes in this country to close the deficit, if we can't get at the social security COLA at least one year for the elderly, or if we can't find some other place to close up that $212 billion deficit, then I think both the Part A and the Part B annual adjustments are in some trouble.

The disturbing thing to me is, Lawton Chiles and I went down to the floor when Gramm-Rudman went through the second time, two weeks ago, with an amendment that would have Medicare be in what's called Category One, where only cost of living adjustments might be affected by Gramm-Rudman, but not the basic program itself. And we lost by a 53-to-42 vote.

The argument that was made strongly against us was that these payments are only payments to doctors and hospitals, and we can cut those payments. So I tell you, the bad news in Washington right now is that people think the Medicare program is only, in effect, excess payments to doctors and hospitals. And so you have a kind of a burden to carry, to a degree, of educating your own members of Congress to the fact that you don't have to practice

medicine, you don't have to take every patient that walks in the door. And you know, there's a lot of cases, a lot of hospitals are going to end up going out of business, if we get to cutting too deeply into that system.

But to be honest with you, it is right now at the stage where it can go either way: it can cut more deeply, or we can start moving more creatively into other systems of reimbursement.

Yes?

PARTICIPANT: The committees, are they aware that the assignment issue, which is about 48 percent or 50 percent of your average (Inaudible) particularly in the primary care of people outside of the hospital, and in Florida, where we have so many elderly patients, we never (Inaudible).

SENATOR DURENBERGER: Right. Oh, very definitely. No, no, I don't have any problem with it. But we are in the minority. The majority of the folks in Washington think you're being over-paid, and the hospitals are being over-paid, and that they can do some more freezing or even in some cases some more cutting into this program.

We also suffer from the fact that we haven't had adequate health policy leadership coming out of the Administration. And that's not the fault of Margaret Heckler; it's really to put the fault in the White House,

where the OMB, or the Office of Management and Budget, has been driving the health policy more than those of us who would like to reform the system.

So I took Jim Miller, the new OMB director, to breakfast last week, and tried to talk to him about some of these things, what kind of a big dollar investment we all have, and tell him how much the doctors and the hospitals in this country have already saved us in the last couple of years, how the doctors are cooperating with the hospitals, how doctors improving their own practice. How many things go on in this place now, in terms of utilization of services, that may not have been going on before.

How much smarter and how much harder everybody is trying now, not to cut corners, but to practice a more conservative practice of health care. And that if we try to take advantage of that, by saying, "Oh, you did this much good for us today. Why don't you do that much good for us tomorrow?" and cut that much out of it, we aren't being fair to the profession.

And there would be some parts of the country that will survive fine; but where you have heavy Medicare populations, where I have heavy rural problems -- I mean everybody is a little different. If you're a downtown, Cook County hospital in Chicago, or L.A. General, or something like that, those hospitals can disappear fairly quickly, and

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those physicians can move or change the nature of their practice very quickly, also.

So, yes, some of us are, but we are in the minority.

Yes?

PARTICIPANT: Are very many others similar with Massachusetts, where they decide (Inaudible)?

SENATOR DURENBERGER: I don't know the answer to that. I don't know. It probably means that they aren't, or I'd have heard about it somewhere else. I take it, you're not in great sympathy with that; are you?

(LAUGHTER)

SENATOR DURENBERGER: Well, keep it up.

Was there a question over here somewhere?

(No Response)

SENATOR DURENBERGER: Okay. Thank you very much.

(APPLAUSE)

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TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

DD Speech to National Association of Bond Lawyers

March 4, 1986

RE: Tax Bill and Tax Exempt Bonds

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SENATOR DURENBERGER: Briggs and Morgan used to be outside counsel to our little company and that's why I know that when Trudy tells you all that stuff she knows what she is talking about. I always talked the firm's advice. I always paid for it. I didn't today, and I appreciate it a lot.

As Marcos said, "I learned my politics from Chicago," so don't count on me to take (inaudible). I got Marcos but I don't think I can do Chicago. That's a little bit too much to bite off. And unless it go by and you give any one person or anything credit, that obviously was credit to a philosophy, a national philosophy of democratic revolution, democratic evolution. Before people too quickly translate that into now that we've toppled a right-winger let's topple a left-winger and find that the Nicaraguans are identical with the Phillipines, I want to caution all of you to spend a little time learning about Nicaragua, Angola and a lot of other countries; Chile, Panama, and a variety of other places if you want to participate in this process.

All I did as chairman of the Intelligence Committee was follow up Paul Lacksall's visit to the Phillipines to Marcos at the end of October with a report from the Intelligence Committee saying that the intelligence

community felt that he had less than two years to live in effect as a president and that he ought probably to start the transition. Instead of starting the transition, he started the election and that started the transition and so the ball started to roll from that point on.

But anyway, we did something right and we crow about that because I usually start these speeches out by asking how many people know what an oxymoron is. That's not a problem of mental retardation, oxymoron are two words that are mutually inconsistent like bond lawyer or honest politician. In my case Senate Intelligence.

You aren't going to believe this, but last term before I became the chairman of Senate Intelligence I was a member of the Senate Ethics. But I also am an avid reader. I am complimented by Trudy's introduction, by her introducing me as her senator. A lot of folks from Minnesota wouldn't quite do it that way. But I do a lot of reading. I thought I would just go ahead and share my weekend reading with you right now as a way of getting us off on the right foot.

First, I want to recommend on the CIA and the State Department interface which is always important, I want to recommend to you Bob Ludlum's latest book, The Born Supremacy, it's fantastic. I could not pick it up. I read it all the way to Tucson, Phoenix and part of the way back

over here and it is just a terrific book. It isn't all accurate I don't think, but you learn a lot about the way we operate covert actions in this country from that.

Now, speaking of covert actions and getting more specific, I am also reading Shirley Christian's book on Nicaragua. There are a lot of good books on Nicaragua. Chris Dickey has done a good one. I think he was with the Washington Post. Chris' book tells you a lot about the contras. This one tells you a lot about the problems that we ran into in Nicaragua. So, I recommend that to you, that kind of reading if you want to be involved in the process.

Then if you want to understand defense policy and how it's made, I recommend the book that brought me to you today, that's the book called Neither Madmen Nor Messiahs. A terrific book. It sold a couple of thousand copies, I think. It's the policy of national security for America by Senator David Durenberger.

(Laughter.)

This is the education of a senator. It was first published in white paper form when it was free back in 1982 when I was running against a millionaire youngster, young man, who was willing to spend whatever it took to beat me, and I wanted to share with my constituents my views on how national security policy got to be made. After the election it was converted into this book that is available at B.

Dalton Booksellers, at still the sale price of $6.95. So, I recommend that to you.

Now, to why we are here. I would recommend to all of you this fantastic book. It's HR-3838. Here is what it looks like. It weighs four and a half pounds. That is why there are no problems, you know, throw it around and toss it around and so forth. It has 1,379 pages to it, about 3,000 sections in it and I am told a thoughtful person could read it and understand it in forty-six hours. Since all of us are thoughtful but we have other things to do, I am going to tell you what's in it, and it will take about thirty seconds.

To those of you who read newspapers or IRS returns, you will know that in Tax Year 1984 George Bush was in the twelve and a half percent marginal tax bracket on an income larger than mine. You don't know this since it wasn't in the newspapers, but my marginal bracket was forty-five percent.

What is HR-3838? It is an effort to get George up to twenty-five percent by promising me I can come down to thirty-five from forty-five. And that pure and simple is it. I don't mean that as a pejorative. I am not knocking George. He objects to my telling this story, I guess, but that's the truth. He was twelve and a half percent because he invested in Houston, and apparently we are overbuilding

in Houston, but there is a lot of creative tax sheltering going on and helping the vice-president of the United States. So, we are going to end that. We are going to end that as part of tax reform.

I move into that in my presentation today because you need to know the difficulty of making tax law with political principles and you need to know how much we need your participation in this process individually and as an association.

We do not have any tax principles to guide us in the Senate version of HR-3838 any more than the members of the Ways and Means Committee who wrote this had any tax principles to guide them. They had some instincts because they are on the tax writing committee, but they had no principles. I think you all know what the principles were, thirty-five percent top for individual rate, thirty-three percent corporate rate which has now been converted to -- this thing still creaks. I remember last year it creaked -- thirty-three percent corporate rate converted now to a thirty-six percent top corporate rate, $2,000 exclusion for everybody or something comparable to that and revenue neutrality. Not a one of those is a tax principle, not a single one of them. Each one is basically a political principle. It is the follow on to 10, 10, 10, 10, 5, 3 which were the political principles by which we started tax

reform in 1981 with the Tax Act of 1981.

Ronald Reagan came to office looking at an income tax in the country that looked like a mountain range, you know. Everybody saw themselves up here in the peak and the neighbor down in the valley, sort of the way it went across America. And so he said, look, it's unfair, we use inflation to build these mountains so we can have a lot of money flowing into the federal government and raising taxes for people and that bothers the state and local folks because then they don't have enough money to pay sales and real estate taxes. So, let's stop these mountains from getting any higher. So, we cut off the tops of all the mountains. We reduce your rates by twenty-five percent and did tax bracket indexing and that was cutting off the tops of the mountains.

But then we had to go for the valley and the question was how do you get to the valley? The valley means base broadening, very simply. How are you going to get to it? We tried it in 1982. We raised $96 billion with some base broadening in 1982. We raised some money last year in 1984, we did tougher in '82 and we did tougher in '84, and all we did was raise money by an effort to broaden the base or go get some extra excise taxes. But the major base broadening Ronald Reagan said could only come if we continue to bring those mountains down. He said the notion was to

bring the folks on the peak down closer to the folks in the valley. Tell me if you can get down to thirty-five percent by bringing George up to twenty-five. That's what the theory is.

Now, if you were on the tax writing committee, you might think that was a great idea. But then it's hard to go home to a state like Minnesota and explain that to your constituents because half of my constituents are in agriculture, forest products, mining, the basic end of transportation, some basic industries. They are not the people in the forty, forty-two, forty-four, forty-six percent tax bracket corporately. Nor are they necessarily the people in the fifty percent tax bracket, marginal tax bracket as individuals. They might be or they might not be. But on a corporate sampling, they're down to zero, one, two, three, four, five, six, seven percent, something like that.

But on the other hand, the twenty-sixth largest employer in America happens to be the biggest company in Minnesota, Dayton-Hudson. Dayton-Hudson says we'd kill for a thirty-five percent rate or even a thirty-six percent rate. So, Dayton-Hudson and 3-M, the second biggest company in my state, Super Value, the third biggest company in my state, General Mills, Pillsbury, I'll go right down the line, those people. They say sorry, you shouldn't be in the industrial policy business. You have no business trying to

hang on to mining, agriculture, forest products, railroads or whatever it is in the tax code. You know, if they can't survive without a tax code then they would come to me and say, look, if you care about employment then look across America and find out where the employment has come since you did that tax bill in 1981. It is all in the companies that pay in the high tax rate. That's what they say, and I am assuming that they are right.

Where is all of the investment coming from? Well, if the investment is coming from the same people that are expanding their businesses and employing a lot of people. It's the folks that are paying the high tax rate. Look down at the other end at the basic industries and they are neither employing more people nor are they expanding their investment. They say, "What do you want America to be?" And I say, "I want America to be some kind of a level playing field." How do we get there? The only way you can get there is with a compass that points in some direction. And this compass, 3838 Treasury 1 or 2 -- Treasury 1 maybe more than Treasury 2 -- Treasury 2 and 3838 don't point us in any direction. Treasury 1 had some direction in it because Treasury 1 went through it and they took care of everybody. My first reaction to that one was, oh my God, I got gored. The second one was, well if everybody got gored then I can beat the other guy.

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So, Treasury 3838 and Treasury 2 don't have it. They are not compasses. They are not pointing in any direction other than base broadening at the expense of rates. So, we are now in the problem or situation facing us of debating tax principles like consumption versus savings and investment or individual taxation and the individual burden of the tax system versus the corporate. Yet we are doing it in the abstract. We don't have any tax principles to guide us.

For example, if we are going to reform the income tax, we should ask ourselves the question and we should get some agreement with the President and the House as to how a tax on income affects the rationale for any income. The first rationale is to have some money to consume things. The second is to have some money to put a roof over your head and food on the table and health care and so forth. The third rationale is a rainy day. That's why I work, so I don't have to work forever, put some money aside. That's why I work, that's why I earn income.

Then I've got the guy next door who makes great widgets, you know, and it is easy for me to give him a few bucks and he does all the work but he pays me off. If his widgets sell he pays me off. That's investment, capital formation.

It also works so that I have a fire department to

protect my home, that I have a police department to protect my family, so that I have a street outside of my house so that I can get to and from work. That is why we have clean air and clean water and schools that I can send my kids to. Where do I buy those services? I buy those services from my local community, by my state government. And so, when a national government is going to tax my income they ought to keep in mind the fact that I have to take a part of that income and I have to buy those services and they way they tax them affects me and the way I buy those services.

In America, obviously, those of us who were able put a little bit of extra effort in to help other people and sometimes we give our time and sometimes we give our talent and sometimes we give from our earnings for other people. And that is an American tradition. It didn't have to be blessed with 501-C345. That is just the way that Americans behave. They help the guy next door, they help the church, you know, whatever it is.

And so in America when you do a national income tax have in mind that that's one of the reasons people put their time and talent into income earning. But do we have the benefit of any kind of a consensus on those issues? Of course not. There is nothing in 3635-2000 grabbing in neutrality the deals with those kinds of issues. Are we doing national tax reform? Of course not. Are we reversing

the trend in the national government where we used to tax property and now we tax income and leave the property taxes to somebody else? Of course not. We are just being more heavily reliant every day on taxing income, and we are not addressing the issue of the cost of labor that goes with the increased taxation on income, say nothing of the cost of capitalism.

In places like this we talk a lot about the cost of capital, but we never talk about the cost of labor. We complain about Taiwan and Korea and places like that, but nobody ever says, I don't think I should pay $6,000 a year for a social security system that won't be here for me.

Now, you are clearly under thirty-five; right?

VOICE: No.

SENATOR DURENBERGER: Is somebody here under thirty-five? Okay, right there. You are under thirty-five? You must pay $6,000 a year; that's the maximum at $42,000 and in three years it will be $8,000 a year. If you've got a husband and he works also, you know, it is $12,000 a year. There is no deductions, no nothing. And there isn't going to be any social security for you. You are paying into a nothing. That is the reality. You have had it. And if you like that --

(Laughter.)

And if you like that, don't complain about it.

Don't tell Ronald Reagan or me or anybody else that it's a real pain in the you know what to paya $8,000 doing nothing so that my folks can live in Florida and I can. I mean I shouldn't complain about my folks because they still think that the Depression is right around the corner. But I know better. Now, I am going to go to Florida or I am going to go overseas on your money or my kid's money, but nobody is complaining about that. So, national tax reform does not take into consideration the cost of labor incorporated into social security, medicare, on top of that unemployment comp, worker's comp and all of that sort of thing.

We set ourselves up over the last thirty years just to consume. We created the word "unearned income" to characterize interest and dividend income, for example, to be a pejorative so that people wouldn't do it. Really, we taxed at higher than so-called earned income. We would earn our income and combine that with borrowed money and we would consume like hell. And the whole tax code was set up to do that. Our people say that we should change that and we should do things differently. But I have a tax bill in front of me that has no principles in it. It has only an effort to fill the vally's by bringing people down from the top of the mountain.

The other thing this bill doesn't do is make a contribution to the deficit. Now, one of the reasons that

it may not make a contribution to the deficit is that people aren't serious about making a contribution to the deficit. This starts with the President.

In 1976 Jimmy Carter ran for president on the theory that he would balance the budget and he doubled the national debt in four years and we threw him out of office. And we elected Ronald Reagan as president of the United States. In four short years, he tripled the national debt, and he carried 49 out of 50 states. So, I might suggest to you that he really believes that there is no problem witwh deficits or he would have been thrown out of office like Jimmy Carter was who only doubled it from $400 billion to $800 million and took the debt service up only to about $47 or $49 billion. Ronald Reagan took the debt service up only to about $47 or $49 billion. Ronald Reagan took the debt service, annual debt service, that part of your taxes that goes to pay nothing but interest on that, from $49 billion to year to $137 and a half billion dollars, this year. He raised the taxes on my kid and I did -- let's not pick on the President, I am just using that as an illustration.

Last year I raised by children's taxes by $10,000 over their lifetime, just for the debt portion of my spending. This year I am going to do it again. God, those poor kids. They're not a kid, I know that, but -- so that

is the dimension. So you wonder why we keep doing that, and I think it is because you know nobody calls us to task for it.

I am reminded of the story about the two Minnesotan farmers that -- this one named Ron had an old mare that he wanted to sell, so he went to his neighbor Tip. He said, "Would you take this mare off of my hands for $5.00, and Tip said sure, I would be glad to. Then Ron got lonesome and he went next door the next day and he said, I will give you ten bucks if you sell them back to me," and so Tip sold it back to them. The next day Tip was sitting there and he said, "Why did he do that? He must have known something about that horse." And the next day Tip was sitting there and he said, "Now, why did he do that? He must know something about that horse or discovered something about that horse. So, he went over to Ron's house and he said, "Ron, would you sell me back that horse for $25.00?" And Ron said, "Sure, I would be glad to." So, Tip took the horse home and Ron sat there thinking, now what does Tip know about that horse that I don't know. So, he called Tip up the next day and he said, "I am really lonesome for that thing. Would you sell it back to me for a hundred bucks?" So, Tip said, "Sure, I haven't made such a good deal in a long time." So, he sold it back to him for a hundred. They kept that up until they got the horse up to a thousand

dollars and then somebody on the other side of the county learned about it and came over to Ron when he had the horses and said, "I will give you $1,200 for the horse." Ron said, "Sold." Off went the horse. The next day Tip came over and said, "I will give you $1100 for the horse," and Ron said, "You're too late, I just sold him to somebody else." And Tip said, "What? You sold the horse right when it was starting to make us a lot of money?"

(Laughter.)

That is the impression I think that you get about this balance the budget thing. Now, the Senate is very serious. Last year we went to the well, 50-49 people. One Democrat plus George Bush who cast his first tie-breaking vote for something other than chemical warfare; 50 to 49 we balanced the budget in 1990. We froze social security and a whole bunch of things. We took it to the House and they said add $31 billion in miscellaneous taxes over five years and we will buy into it. We took it to the White House and the President said you didn't hear me when I debated Walter Mondale, no new taxes. So it died.

We came back with Graham-Rudman-Hollings, which is nothing more than a decision to take decisions. The first part of January it was one trillion dollars worth of decisions and now that's been escalated down to somewhere in the neighborhood of five to six hundred billion dollars

worth of decision. And take those decisions we will. And that's how we get the tax exempt bond financing or whatever it was I was invited to speak on. That covers some of the things that we don't want to do at the federal government level any more. We want to run a Pentagon, we want to run a Social Security Administration and a pension operation and we want to run a T-Bill thing in Treasury and that's about all we'd like to do around here.

Just look at what we have been doing since the beginning of the decade as projected out to the end of the decade and you will know what we are up to. The percentage of federal spending that goes into defense in the beginning of the decade was 23 percent and at the end of the decade 32 percent. On debt service at the beginning of the decade nine percent and at the end 17 percent. On entitlement programs, social security, Medicare, the welfare programs, pension programs, at the beginning of the program 42 percent of federal spending and at the end of the decade 37 percent of federal spending.

All other government, everything else that you can think of, including general revenue sharing, (inaudible), CDBG's and all the other things we sent down to local government and state government, everything else was 26 percent of federal spending at the beginning of the decade and it will be 16 percent of federal spending on the

current spending policies by the end of the decade.

Now, the President this year set up a budget that said take another nickle out of every dollar of domestic spending. Only when you look at where he is taking it, he is taking about twenty cents of it out of the state and local government, you know get rid of permanent general revenue sharing, get rid of U-DAGS, I guess, cut back on CDBG and on and on and on. Find all of these places that you can stick a crimp into the non-means tested aid to state and local government. Start to block some of the infrastructure programs, particularly in highways and in the environment area.

The signals are we're bailing out on state and local government. Very clearly, we're getting out of the business. So, the question is what will our policy be vis-a-vis the rest of the people in this country? Pete Dimeneche came to the Finance Committee this morning and pleaded with us. Pete and I are both on something called Environment and Public Works. In effect he was pleading with us to say why don't we chop the public works part of that off? What business do we have financing pothole filling all over this country? What business do we have wrestling with Tip O'Neil over a new freeway in Boston? What business do we have fighting over flood control projects in Rochester, Minnesota and places like that?

Let's get out of it. But we can't get out of it, you know, because there are too many politicians that have some kind of stake in doing public work. So, we get halfway out of it which means we keep increasing the funding.

And so how is the decision process going to be made? Pete's suggestion is, and I certainly agree with it, and that is that we explicitly devolve infrastructure funding to state and local governments to do something about federalizing the income maintenance programs, not meaning that we take over all the funding of it, but that we make some sense out of the welfare and income maintenance program in this country. We start devolving infrastructure programs, and that includes highways and wastewater treatment and solid waste and transit and a whole lot of other things. But you just don't do that on the United States of America as though the 39,000 units of government are all similarly situated. You can't do that. And we know that.

See, we created the income tax and put inflation into the income tax in this country in the '60s because we saw people going out to the suburbs. So, if you just taxed property, people would keep going out to the suburbs because the high cost government were in the cities. That's why they were going to the suburbs in the first place. So, if you continued as a nation to tax property, pretty soon there

would be no property left to tax. So, as a nation we decided to switch to taxing income. So we follow the flow of income out to the suburbs where we tax it and brought it back into the cities by way of grants, one kind or another. We spread these grants all over the country just to get the job done. There was a lot of waste and inefficiency. But, there was something behind it. There was a theory of spreading the burden. And so we spread the burden across Mississippi and Texas. We put the same tax on property, consumption or income on Mississippi and Texas, you will raise twice as much money in Texas.

Now, is that your idea of a nation? Should we cut and run on Mississippi? I don't think we will ever equate Mississippi's taxing capacity with Texas. But somehow a nation that has to educate its young and provide for its needy can't let that situation exist, and so we haven't. We have deductibility for state and local taxes. It has been there since 1913. It's a match to the effort that Mississippi puts out if Mississippi puts out an extra effort. It's a match that Minneapolis puts out that maybe Edina won't do out in the suburbs or somebody else. So, that's what deductibility did in addition to all of these other kind of programs.

When Jim Baker came to the Finance Committee and said we have got to get rid of deductibility, I said

somebody ought to find out from the mayor of New York City how many undocumented workers, illegal folks, there were in New York City. The answer came back 750,000. So, I said, Jim, you know there are more people in New York City illegally sucking up the hospital system and everything else in that city than there are people in Wyoming. Do you want us all to be the same? Where is Wall Street in Cody, Wyoming? Where is the Metropolitan Opera? In Cheyenne? No, of course not. This is one nation, and we are different in different parts of the nation, but as a whole we are better than anybody else. But it is because we are desperate and we have different capacities and we deliver different products that we are so terrific.

And so a federal taxing system in its effort to subsidize, if you will, access of people to services will operate differently in different parts of the country. That is the argument for deductibility basically. The argument for tax exempt bond financing simply is to pick up the slack in infrastructure. And the debate we had this morning with Pete was best illustrated by the two questions that he got before they got to me. Bob Packwood said, "Some guy from New Jersey came in here and told me that 'anything that creates a job ought to qualify for tax exempt bond financing.' And he said, 'Pete do you agree with that?' and Pete said 'Yeah, I was the mayor of Albuquerque, of coures I

agree with that.'" But, you know, we can't afford to do it. So, we have to cut back in some way.

So, then George Mitchell asked him the question, "On an efficiency scale is tax exempt bonds more efficient than giving money to local government?" And Pete's answer sort of evaded the question, so between Pete and I we answered it thusly, that on a sheer efficiency scale, how many dollars actually get to the service in the abstract: general revenue sharing is 99 percent efficient and categorical and block grants are probably 88 percent efficient and categorical grants are maybe 84 percent efficient and the efficiency of tax exempt bond financing after you deduct the price of getting the money out there is somewhere between 65-75 percent let's say, somewhere in that ballpark. So, on that measurement it's less efficient. But on this measurement how much money do you actually end up spending when you let the marketplace determine where the money comes from, rather than the public works part of Environment and Public Works, it is a winner by 7,000 miles and several millions of dollars.

We have been sitting on a water resources bill in the Environment and Public Works, the Senate and the House, since 1977. I have got a flood control project in Rochester, Minnesota that could have been built for $12 million and the price is now up to $72 million. I've got

three freeways in Minneapolis/St. Paul and Duluth that will cost $375 million to finish, but when they were proposed, the if somebody had been able to go to market on those freeways when they were proposed, it would have cost $72 million, not $375 million. So, it is part of the way that we make decisions in America that makes public benefit or tax exempt bonds so good.

I watch the hospital market. I am an expert on hospital financing and that sort of thing. So, I watch the way the market feels with the delivery system in health care. And I'd sure trust that a long time before I'd trust the Senate Finance Committee or Environment and Public Works Committee or anybody up here to make the decision about where to put the next hospital. Let the market do it. And that's where tax exempt bond financing comes in and that's where Margaret Brightson comes in. Margaret will stick around and answer all of your questions on the subject, I am sure. If time permits, a quick overview. We got rid of essential and nonessential and we are going to governmental and quasi-governmental.

Governmental bonds are those where no more than 25 percent of the benefits are used in a trade or business, or where no more than 25 percent of the revenues are derived from a trade or business. Quasi-governmental bonds are those that exceed either of those two tests.

There are basically three categories of projects covered within the definition of governmental; publicly owned and operated facilities, publicly owned facilities operated by a private party under a management contract like airports, convention centers and irrigation system, and three public service facilities owned and operated by a private owner, like water, sewer and solid waste.

It should be noted that both multifamily rental housing bonds and tax increment bonds are deemed governmental and not subject to any volume cap. The governmental is our way of getting out and getting rid of Rawstenkowski's volume cap.

Quasi-governmental bonds would be capped at $225 per capita per state or $260 million, whichever is greater. Bonds covered under this category include single family mortgage bonds, veteran mortgage bonds, student loan bonds, private loan bonds, bonds issued by 501C3's, small issue, IDB's and industrial parks. Advance refundings: You can't have everything, so on advance refundings it shows you where you can't have everything.

The only bonds that could be advance refunded are those in Category 1 of governmental bonds, that is publicly owned and operated, and 501C3 bonds issued by nonprofit hospitals. That shows my bias. Such bonds could only be advance refunded twice and the aggregate amount of refunding

bond would not exceed 250 percent.

Early issuance restrictions, five percent of quasi-governmental bond proceeds would have to be expended within 180 days, at least 20 percent of the proceeds of governmental bonds would have to be expended within the first year or the bond yield would have to be restricted.

Five percent of the proceeds of student loans, mortgage subsidy and veteran's bonds would have to be committed within 180 days or bond yield would have to be restricted.

Arbitrage issuers of Category 1 governmental bonds could earn unrestricted arbitrage for a temporary period not to exceed one year. However, for construction projects, the temporary period could be expended by one year if at least twenty percent of the proceeds have been spent for the purposes of the issue. The temporary period could be extended an additional year if it least 50 percent of the proceeds have been spent within the first two years. If the issuer fails to meet the spending requirements, the temporary period terminates and the yield is restricted. Quasi-governmental bonds in Category 2 and 3 governmental bonds may only earn unrestricted arbitrage for six months.

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VOICE: I would like at this time to introduce Senator Dave Durenberger from the great state of Minnesota.

(Applause.)

SENATOR DURENBERGER: Thank you very much. Thank you for giving me three minutes to eat lunch. I appreciate that. It is all my fault. I was looking for Khadaffi. I can't find him. A lot of you are probably his personal friends. I found out about Khadaffi the other night when I was in Minnesota -- I've got to tell you this -- that my daughter-in-law Jo at least knows that I spent part of the week even though we were supposed to be writing taxes every day, spent part of the week in Minnesota because we were raising money in St. Paul on Monday night.

At about 5:00, 5:15 or 5:30 in the evening I am seated at the head table of this big fundraiser dinner which preceeds a new musical. I am sitting next to Jihann Sadat who is the wife of the assassinated president of Egypt when I get called out to the telephone. I get a telephone call, "Senator, the Washington Post is reporting that we are about to bomb Libya." I go, "What's the intelligence -- what does Bill Casey say?" And he said, "Well, Casey won't return our phone calls, he's not talking to us." I said, "Well, how about the National Security Council?" "Well, they are all

buttoned up down there. They won't talk to the Congress either. In about a half an hour there's going to be a briefing session though, and if you were here in Washington you could go to the briefing session." I said, "Well, can't they tell me on the telephone?" And he said, "No, they can't talk to you on the telephone." Anyway, the Washington Post says we're bombing Libya. So, I went back in and said to Mrs. Sadat, I said, "We are bombing Libya." She said, "What?" I said, "I thought you'd be happy to hear that. Your husband certainly would have been happy if you aren't." Then she made the very astute observation after she asked me to describe what those raids might be -- made the very astute observation, "If you are going to try to deal with a cancer, you don't spend all of your time and your money just on the periphery of the problem, making the patient feel good and then occasionally blasting him with a keyhole or other therapy treatment, you go right to the heart of the cancer as quickly as you can." And I won't say any more about the advice that she gave me about going right to the heart of the cancer, but I think a lot of you in this room understand what the ultimate solution to this problem in Libya is going to have to be.

As is the ultimate solution of the problem in Iran, potentially in Syria and any of these nations that decide to make it national policy to declare war. You know,

they all get the questions now, "Where are we headed with this? Well, you are chairman of the Senate Intelligence Committee." I just sort of chuckle at that because those of you who know what an oxymoron is, this is an oxymoron. An oxymoron is two words that are mutually inconsistent like honest politician.

(Laughter.)

Or, Senate Intelligence.

(Laughter.)

So, when I say Chairman of the Senate Intelligence Committee, I have become the oxymoron. I know you will consider it very funny that I used to be also on the Senate Ethics Committee. But anyway, "you are chairman of the Senate Intelligence Committee," and speaking at getting to the heart of the problem they say, "Well, wouldn't we solve all of these problems if we just solved the Palestinian problem?" "Where did you ever get that idea?" "Well, if we just solved the Palestinian problem that the Khadaffi's would go away." I say, "Are you kidding? I said to take you back in history you know, Khomeni, Khadaffi and we'll go back to Adolph Hilter, we can keep walking our way back through history. These kind of people make up their causes. If we fall for their line, which is they've got an excuse for doing what they're doing, then where does it end?"

Do you support the President? I support the President because there isn't anything else that he can do. He has gone through steps, gone through about ten steps and then working up to this one. He is at this one now in the hopes that it sends signals around the world. But it is a difficult situation. We have not solved the problem. Khadaffi apparently is still alive. He is in the south of the country where he usually goes, or often goes when he doesn't leave the country. But he is probably still alive. They seem to be quelling whatever little revolts were taking place yesterday. So, it looks like somebody is back in charge. and most likely that he is back in charge. So, then it now becomes a burden on this government to stay on the course rather than (inaudible).

I know a lot of Americans are getting very nervous and they want more guards around Washington and all this sort of thing, but in defense of a nation which undertakes to be emulated and who sends signals to the rest of the world, we really get to the point where unless somebody takes charge of this situation, nobody is going to take charge of this situation until the President has chosen this particular course of action. It puts a little strain on our credibility sometimes, because we don't like politicians very much unless we know them real well. We don't trust our President, we don't trust our country a lot

of times. We tend to doubt. We insist on information. Everybody wants to know what's the connection? Show us the information. Well, at some point you have to trust your leader on some of these issues.

But it's hard because we're entering into a kind of a new era of war planning which puts another strain on us -- you didn't want to hear all of this, but if you hadn't reminded me that I was in St. Paul on Monday night (inaudible). But we are now entering into a new era of war planning. There is for some period of time going to be a big war with the Soviet Union. That is what we have been trained to prepare ourselves for. We measure the Soviet Union's capacity here and their capabilities there and their new technology there and the number of missiles and warheads and watchers over there and all that sort of thing.

The reality is there are forty-two wars going on in the world today, forty-two of them. There are four million people directly involved in these forty-two wars. And it is part of a deliberate -- part of it is socioeconomic, but a larger part is the fact that they've come to the war status at our level is in fact a deliberate policy of the Soviet Union, to keep proxy wars going. That is part of the Gorbachev succession process. That is how he becomes the leader, he has proxy wars going on all over the world one way or the other. Look to him for a solution to

the problem in the Middle East or anyplace else, he is not going to solve that problem because he has to keep us sort of on the hook, keep us on the hook with all of these little things going on all over the world. Do you think he could have solved the arms control major nuclear arms reduction problem quickly? No, because it is in his interest not to solve that one very quickly. That's our tough one. We all live in fear of a nuclear holocaust. So, the longer he keeps it as our problem and not his problem, the more advantageous it is to him.

But the real problems get to be the sort of in between problems, what causes these forty-two wars to take on. It gets to be the Third World problems, the expectations. It gets to be the oil problem. It gets to be the debt problem, the world debt problem. George Bush is absolutely right when he says we have to do something about the free fall in oil. I am a consumer. I don't have an oil well in my state. Do you want one?

We have got to be more (inaudible) at the gas pump. We have got a lot of people that buy it from other states like Texas and so forth. We don't have it in our state. But I admit, we have to do something about taking back control of world energy policy, because without that kind of control it creates economic problems all over this world. The first one is going to be from Mexico, and in a

year or year and a half it is going to blow up unless something is done about some of these. If Mexico blows -- you know, you think Nicaragua is a problem, but there are only three and half million people in Nicaragua and none of them or very few of them -- there are a handful of Communists and that sort of thing -- they aren't in any great rush to attack Houston or any other place if Mexico goes down.

You think it's bad for the banks in Oklahoma and Texas now. If Mexico goes down the tubes the whole economic world is going to shift from the Pacific where it is now in Japan and Taiwan and Korea are all going to shift into the (inaudible) of this hemisphere. A very serious potential problem.

So, we are waging our wars now in different places, and they are being impacted by drug dealers and by terrorists and a whole lot of other people. So, I tell you that only because it is hard to get an understanding of what is going on in the world just by reading newspapers because the newspapers -- Do you ever read the front page of your newspaper? One day it is Nicaragua and the next day it is some other place. You can't keep track of the issues. If you only have five minutes a day to watch television you are depending on the first five minutes of the 6:00 o'clock news or 7:00 o'clock news. And so when there's a contra revolt

on we all get that right up in front. As soon as the contra revolt is over, then the folks are on to something else.

How can you consistently develop an opinion and be a participant in a process where we're in a shrinking world? It is very, very difficult for you. Yet you've got to. You absolutely must be part of this process. Right now the world is getting so small that there is a piece of it for everyone of you. I think that is one of the reasons that you associate in groups like this.

If somebody asked me what your association does, I'd have to go back and look at some kind of a list of your priority issues and all that sort of thing. I have done it. I know where you are in the tax issues. I know that I am carrying the amendment that wholesalers and retailers and you folks don't get stuck with the proposal on capitalization. I know that much about the bill, only because I was in business myself and we used all of you. We were in the specialty chemical business. We had a lot of glue running all over the state, a lot of chemicals running all over the country and so forth, and we were dependent on your recycled containers and all that sort of thing. So, I know a little bit about your business.

I know that as people you have much broader interests in where the United States is today and where we are headed in this larger context. So, I am not making a

speech on all of the ills that face the world nor all of the opportunities, but I sure can't stand here as the first Republican senator reelected in Minnesota in thirty years and with Rudy Basha (phonetic) the first two Republican senators ever elected at one time in the State of Minnesota and tell you things are different. I mean, who knows which is the one state in the United States that did not vote for Ronald Reagan? Is there any doubt? And yet it was that same state that elected two Republican senators, and reelected both of them. In my case they ran a Democrat against me that spent seven and a half million dollars of his own money, and I got reelected. That tells you something is going on in this country and it is reflected in a lot of ways that I think with which you are fairly familiar. Something is going on. People do feel better today than they did yesterday, and their optimism about tomorrow is sort of renewed.

But when you put it in the specific, what do you think of the President's tax plan; good and bad. What do you think about Libya? Oh, not sure. What do you think about Nicaragua? I'd rather not think about it.

But when you take it out into its little pieces then we all tend to sort of analyze it on the basis of our past experiences. But I think we are entering into a period of time in which nobody has asked me to act on faith. In

fact, just the opposite. I think I am asking you to get more involved in a wider variety of issues because it is easier today to become involved. When Hubert and Fritz Mondale and Eugene McCarthy and guys like that who represented our state in the United States Senate, a lot of the solutions to problems that they perceived as facing the people of this country were legislative solutions. They'd come and find a problem in Minnesota that Minnesotans have solved and they look around at the rest of the country and found that nobody had solved the problem, that everybody had it. So, they can come to Washington and they can say, "Hey, we found a way to solve the problem. Can I get 51 percent of you to agree that you've got the same problem and I will give you a solution." And they find 51 percent and then they write out a check for a regulation or a tax policy and you have it. You have the solution to the problem. And we have been doing that for thirty years in this country.

And we concluded in the late '70s that it cost the election to approach it in that way, not that those weren't the problems that needed solving. But we needed to find different and better ways to solve the problem. So, it gets harder to represent people today than it used to. And for that reason we are much more dependent on people as a result, much more dependent.

I spend a lot of time talking to people and feel

I've got a lot to learn. Everyday I learn something new. I am like a sponge. I go around and say if I make a little speech like this and I squeeze out some new things that you've never heard before and then I relax and I go for the questions and I learn something. It really is amazing. This place is populated by a lot of people like that. You would be amazed. We all sound like we've got all of the answers but we just make those sounds so that we can get your attention. And then the smart guys relax and then they can absorb what they've been told.

So, where are we headed? In basic principle I'd say we are headed from between generations. I have written two books, as Piranha Press (phonetic) my publisher is sponsoring my being here today. The first one is called, Neither Madmen Nor Messiahs: The Policy of National Security for America. Barry Goldwater when this book came out -- and not a lot of people have read this -- Barry Goldwater read it when it came out cover to cover and today he is reforming the -- starting the process of reforming the Defense Department. Not that they got stimulated just by this, but this sort of put some things in context.

The second book is called Prescription for Change, which is about health care, what we are doing with health care. I think many of you know that there is a revolution going on in the way we pay for health care. But

this sort of thing is premised on the notion that my generation is about to leave its kids less than we were left by our parents. My generation like me was born in the Depression. I was born in 1934. I know you have a hard time believing that, but 1934. I was born when my folks agreed that I was all they could afford to have. So, they had me and they had my sister and then they had another one. They had kids in those days because they had to have something to take care of them when they retired. That is one of the reasons. But it was sort of a reality.

We had tough times in the Depression. When they came to power after the Second World War they decided they shouldn't have to put me through what they went through. So, they created having without paying for it. They gave me a $500 home. They gave me the opportunity to own a home for only $500 down for however long it takes; thirty years at least, four and a half interest rate, and all of it deductible. That was about 1959 when I bought my first home for $500 down. It was a $12,000 home. I sold it three years later for $22,000. It went up so quickly because everybody in the country had $500 bills and only half the peole had homes. That is basic economics. You've got twice the demand as you have a supply so the "haves" can increase their price. Carpenters go from $2.00 an hour to $4.00 an hour. Rudy Vargas went into employ with them in Minnesota.

So, we built a whole society of my generation on the notion that you could have lunch without paying for it. We took group health insurance and said, that's a great idea. Let's give everybody a deduction. If you give the health insurance to your employees then you ought to get a deduction of the employees that don't have to pay tax on it. Everybody said, that's great, that's terrific. It happened in 1954. That's terrific. The unions got wind of it and they said, hey, that's a hell of a deal. Where should you get your health care? Get it at work. Every time a new idea for health insurance or something new to be covered, teeth, eyeglasses or whatever new came along they put it in the health plan.

My generation got the notion that it was better or at least easier to be sick than it was to stay healthy. Well, of course if you insisted on going to the hospital or seeing the best of doctors or whatever it is, we got rewarded for it. The only place you get rewarded in society with flowers and cards and things like that is if you got sick. Even the employer pays the bill if you go to the hospital. If you say well, you've got to work. Nobody sends you flowers. Nobody says, thank you for working today. Nobody sends you a card. That's not the way I was raised. Is it any wonder than if I was raised in this environment that I could leave, I could smoke myself to

death and somebody would give me -- I have a right to drive a car without a seatbelt. If I bash in my brains somebody is going to take care of me. I could ride a motorcycle without a helmet as the same thing.

It gets really serious when you look at this generation, when you see that program, that CBS program about a month or so back, talking about that Bill Moyer special, you know they look at the black kids in the ghetto. I have to look at them. All these studs are running around playing daddy without any responsibility. And the girls are playing mommy without any responsibility. You know, that beats the whole set of records. And then at the end for a half an hour four black leaders of the country never once criticized Ronald Reagan or the Republicans or anything else. They bemoaned the fact that here comes another generation without any responsibility. Why?

Ask a hospital administrator about the malpractice premiums that they have to pay for. I asked one down in Puerto Rico when I was down there the first of the year, he just paid off a settlement to a woman who was 55 years old and had massive heart problems, she was up in intensive care of a very nice hospital, I can't believe her husband brought the cigarettes to her. When she got her head outside of the oxygen tent -- they couldn't take care of her in Puerto Rico so they took her to Houston Methodist,

Debakey, the best in the world. He did a triple bypass and she died. So they sued him, Houston Methodist and the hospital in Puerto Rico. And they had to pay up. And the hospital administrator says why should I pay you for self-inflicted injuries?

The point of all of this I think is that we are all in this together. You know, my generation has somehow adapted to the notion of consumption. It certainly has not adapted to the notion of savings and investment and things like that. We had a great opportunity to do that by manipulating the tax code in one way or the other. Now we are in the process of either unmanipulating that or something else. But in the context that we're doing tax reform the rest of this country is starting to deal with responsibility. I ought to have the right to pay them, but I also have to have the right to be rewarded for my success. If I save for my rainy day, I ought to be rewarded. If I invest in the guy next door with a great idea I get rewarded for that. If I just consume, I wonder should we continue to reward people for just consumption, which of course is what we do with our taxes.

If you want to have an ideal tax code, income tax code, I guess you'd set it up on the basis of some principles, like you can do one simple one which would be not to tax savings and investment and you only tax

consumption. That would be an interesting way to put your tax code together. Those of you who don't like the fact that the tax code is now so big or thick or something like that, you find a very simple income tax if you just adopted that program. Then you'd have to define what consumption is. But we are not doing that this year. This year we are only lowering the rate on the income tax by broadening the base, and that's where you all come in. You are all part of the base and now we are trying to find some way to get you to pay taxes off of something that you currently expense that we're going to capitalize in some great way, or we are going to do something else. We have to pick up some money off the base so we can bring the race down from 46 percent of appropriations down to 35 percent.

Now, I know a lot of people in this room are in the highest tax group; so am I. I am in the fifty percent rate. You can't get any higher than the fifty percent bracket. Don't make enough money to have a lot of shelters, but make just enough to get into the fifty percent bracket.

I know what I am talking about because George Bush last year was in the twelve and a half percent bracket. He made more money than I did. I usually say when we are doing a tax reform is to get George up to twenty-five percent by promising me I come down to thirty-five percent. But honestly, you come on up there with me and listen for

awhile and you will have a hard time finding tax principles.

Now, just what can you scrape out of the base by attacking health care there to bring the rates downw. That is basically what we are up to. There are no principles. We have our own set of principles. Yesterday on 401k's I voted to lift the $7,000 annual cap on 401k's and I voted with Chuck to take it up to $12,000. I would have left it at $3,000, you know, if I had that opportunity. But we had to close it down a little bit so we could make some money until we got rid of that in rate reduction. Where is the principle? We're without it. I don't mean that on an individual basis, but I mean that on a collective sense.

But please forgive us as we go through this process for our mistakes, because our mistakes are only twenty honest people on the Senate Finance Committee who differ on the isssue of what they think tax credit will buy. I mean we are not being given any leadership on this, where the country ought to be going. With a move from a consumptive society to another kind of society, we ought to start making that decision. It doesn't have to be drastic, we don't have to cut everybody off and what not, but at least we ought to point this country in a new direction.

I think over the next five years you are going to help us point the country in that direction. I think you've come to the conclusion that we can't have a free ride any

more individually. We can't live off somebody else and we sure as hell can't live off our children which is what we just designed this system to do.

You look at the people you employ, the $6,000 per person on just social security, medicare and disability. Every person you employ costs $6,000 for social security. In three years it will be $8,000. If you employ two people in the same family that will be about $16,000, no exclusions, no exceptions. Today social security is $7 trillion. That means for all people we are currently recognizing that we have to get the maximum payroll tax rate on social security up 35-36 percent in order to fund everybody the benefits that they're at.

Now, wouldn't it be wonderful if today I went back up there and you said, let's take this income tax code and divide it as consumption here and savings and investment there. We will not tax it until it is taken out. We will put it all on the consumption side. If we had ten or fifteen years of that very simple principle, you save then you don't pay taxes on it. Ten or fifteen years of that it would be real easy to meet social security, real easy. But you have to start somewhere. You can't start with the (inaudible) of social security, you start with tax policies that give you a signal when you go to work and you earn some money that the money that is from that earning that is saved

there is nothing that is taxed, or some other principle which is all.

I am going to shut up and -- You know, I can go on forever. But I would be more happy to respond to questions from people in this group. With that, may I have the first question? Speak up.

(Conclusion of speech.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

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Now, what would have happened if Mabel and I had gotten married? It's the truth that's what they call (inaudible) county syndrome, too many first cousins liking each other.

(Laughter.)

We are all (inaudible) with very few exceptions to that. And the exceptions were all brought in by Garrison Keeler when those of you who listen to the Prairie Home Companion, or who made Lake Wobegone a very famous book. You should know that Garrison Keeler is talking about Stearn County. Garrison Keeler was raised in Anoka, Minnesota which is a suburb of Minneapolis where he met the Swedes or the Scandinavians in Lake Woebegone. But he went to school at St. John's the same way as I did and it was from that he picked up all the rest of these characters and he incorporated some of the Swedes into the characteristics that he attributed to everybody else in Lake Wobegone. But those of us who come from that part of Minnesota know that's where Lake Wobegone is, where all the women are strong and the men are good looking or something like that.

I don't know what Wendall Ford told you, but he's full of it.

(Laughter.)

He was a neighbor of mine up on the third floor of the Russell Building and now he is a neighbor of mine on the first floor of the Russell Building and that guy blows more smoke than anybody I have ever seen. He is a great champion for tobacco, but he is funniest -- and I know he was funny here telling you all of the Kentucky stories, I am sure. He is a former national president of the JC's, and a Kentucky JC president. I have to brag about that because I was a JC president in my time too. But there just ain't nothing like Wendall Ford until you've heard him in Kentucky. Are there some Kentuckians in this room? Well, then you know what I am talking about. I tell you, that guy -- not only is he an old shoe, he's an old overshoe and a buckle overshoe. I have been to Kentucky with him a couple of times and once on the same platform with him. I tell you, you can't even understand him when he talks like that. He is really something else.

Despite all that he is a Democrat, and I don't know why. We started a revolution in Minnesota in 1978, we elected two Republican senators in the same year after Hubert Humphrey, Walter Mondale, Eugene McCarthy and all of these democrats that had been representing our state. Three years later, the country elected sixteen Republican senators in places like Alabama, which didn't even know what Republican was, they elected a Democratic senator there and

all over the country. And they elected a 70-year old movie actor as President of the United States. Why did the country do this? Because the common sense seemed to be that everything that government seemed to put his hands on ended up costing too much money.

So, we started a move in this country called balancing the budget. We thought that if somehow or the other we could get the politicians to balance the budget, they would learn how to do things differently. So, we started with like Proposition 13 in California, or two and a half from Massachusetts where they cut off the water so they wouldn't spend the money. What's politicians water? It's tax money. No more taxes, you can't raise taxes any more, because if you raise any more taxes all you are going to do is continue to spend. Then I am going to look at that spending and I am going to say, it just costs too darn much and produces too little. So, for a fairly large period of time now, eight to ten years, we have been living with a demand by the public that we not raise taxes as a way to make sure that the politicians find better ways to do things. We are still living with it and the subject of tax reform is a part of that that I am supposed to talk to you about today.

First, I had better get a plug in for my sponsor here today which is another Minnesota company called Pirana

Press, my publisher. Now, probably a lot of you didn't know that I wrote a lot of books. I do. My first one is on national security policy. It looks like this and is available at B. Dalton Booksellers. It is not yet a best seller. It has got some great pictures in it. There is a picture of me looking through a periscope on the S.S. Minneapolis/St. Paul and there are some pictures of other people. There is a photo in there by Jean Kirkpatrick and by Jim Schlesinger both. So, it has got to be a very good book. It's just that people weren't very interested in national security reform until last Saturday. Now, the President gave it five minutes on his radio show, and I think people will again be interested in reforming national security.

So, after a few years of reform to the national security policy people begin to say, well, now, maybe it's worth contributing to the national defense again. Health care, which is one of my specialty areas, we have been reforming that system for the last five years. We have saved Medicare $30 billion, we have saved Medicaid money, we have saved a lot of people by changing the way we buy health care in this country.

Some of you now know about DRG, Diagnosis Related Group. You heard about HMO's, PPO's and IPA's, all of this competition. Some of you come from states and cities where

all your billboards all over the place say "Buy Maxicare" "Buy Cignacare", buy this, buy that. We are changing the way the system operates by using the marketplace. So, there is some reform going on.

As Chairman of the Senate Intelligence Committee and when I say Senate Intelligence I have to ask how many people know what an oxymoron is. That is two words that are mutually inconsistent like honest policitican.

(Laughter.)

Or Senate Intelligence.

(Laughter.)

I tell you that the year before last I was also on the Senate Ethics Committee. But on the Intelligence Committee I have been chairman for the last year and a half. One of the first things that I did was to divide everybody into producers and consumers. I said the Secretary of State and the President and the Secretary of Defense are all the consumers, they need intelligence information, so they are willing to buy. And the intelligence community are the producers, they are willing to sell. If we could just set them up like buyers and sellers we could get all kinds of efficiency into the system. So, I thought now what am I going to do? I am going to call all of the consumers in one at a time, the National Security Council, the Secretary of State George Schultz and all of these people, and I said,

let me see your order plan. Every time something goes wrong in the world you blame the intelligence community. I want to see your order plan. What have you ordered by the way ofintelligence?

And of course all they ordered was information or they ordered no surprises and things like that. But did they order up information like Central America before 1977 and 1978 when that thing went downhill? No, they didn't. Did they order up much information on the Philippines? Well, fortunately on the Philippines they were starting to order up information.

How much information nas this country ordered up? Intelligence hasn't ordered up. What would happen if oil prices go down to $8.00 a barrel? Watch any program tonight or last night or over the weekend, this country is divided on what would happen on that because we haven't spent any time thinking about it. What would happen if the Arabs deliberately set out to take the price of oil $32 or $28 a barrel down to $8.00 or $6.00 or $5.00? Has anybody figured that one out? No. But they are going to figure it out in the process right now. And if you're from Texas or Oklahoma or places like that, you know what's happening. But the rest of us from the consuming states don't know what happens until they drive a whole bunch of you people out of business and then take those prices back up to $28 or $30 a barrel

again. I happen to think that's what's going to happen.

There are two guys over there that say, oh my God, the price of gas is coming down and now I can go buy myself a couple of new big cars or big new boat or something like that. They forgot about '79. They forgot about '73, except groceries. But you haven't forgotten about those years. You haven't forgotten about how the government had to go into the energy regulations business and all the rest of that sort of thing and how we had to do the tax credit and do this and that and the other thing. So, dividing people and putting people into the marketplace in this country is a pretty doggone good idea, and for too long we have been reducing the system of what would happen if the government had to go into -- Now we are showing how it can be done. It can be done in intelligence, it can be done in health care, it is going to be done in education, in elementary and secondary education in this country. The time will come when we change the financing of elementary and secondary education by giving the money to the consumer of education rather than giving it to the school board, you are going to see changes in elementary and secondary education that are good. When people are given choices and the wherewithal information and money to make good choices, you will see a growing marketplace out there, just like you'll see in any other kind of a business.

So, part of the revolution that is leading us up to tax reform and all the rest of this sort of thing that is going on in the country today, is how do I get something back for my money? A lot of us spend a dollar and want to get a dollar's worth of service.

Now, for thirty years I can understand why Americans haven't cared a lot about quality of one kind or another. Unless you are operating on a one percent profit margin like all of you people are, then you don't care a whole lot about quality. Those of us who have been buying cars for the last thirty years haven't worried about quality. Give me the chrome, give me a new gizmo, gadget, whatever it is, I don't care about the quality.

Now, for all of our lives during the last thirty years we have been taught in effect that it is good to consume and it is not very good to save or invest or something like that. It is not good to buy quality, but it is good to consume it in whatever form it happens to come.

The national tax system in this country is prefaced on consumption. it is not prefaced on savings or investment. If you want to get savings or investment out of it then you have to create some kind of an expenditure loophole to crawl through tax preference, as we call them. The whole code is oriented towards consumption. And as all of our society has been oriented towards consumption.

My folks had me up there in Stearn County in 1934 when I was all they could afford to have. And they had a lot of us in those days, because that's all they could afford to have. They had kids. They had kids for another reason, because kids take care of them when they retire. But the Depression was tough, and when it was over and my parents' generation became President of the United States and senators and things like that, the Humphreys and Kennedys and you name it, they swore their kids would never have to live through a Depression. They created havoc without paying for it. They gave me -- I was the first recipient of my generation of a $500 home. I paid $500 down for my first home in South St. Paul, Minnesota. It cost me $12,500 and I had thirty years to pay at a four and a half percent interest rate and it was all deductible from my taxes. And when the word got out in 1959 that anybody could have a house for $500 down, you look around the country and everybody was waving their $500 bill. There were more people with $500 bills than there were homes. So, what happened to the price of homes? Well, I sold my first house in three years for $22,000. I took my $500 down and bought another one and sold that one for $50,000. The last home I bought in Minneapolis in '71 I paid $77,500 for it and sold it in '78 for $245,000. Then I came out to Washington, D.C. and I put $187,000 into one home out here and $45,000 into a

condo in Minneapolis and shoved a few improvements into them so that I could take advantage of capital gains. Today one of them is worth $400,000 and the other is worth $65,000. You can ask what my generation did. It helped.

We used group health insurance. Went to work for XYZ Company and they give you free health insurance, right. Sure, it's free health insurance, paid for by somebody. But that's the way it's been in my generation.

In 1954 the tax code said it's a good thing to buy health insurance at work, so we will give the employer the deduction and we will not tax the employee on the premium. In those days the premium for health insurance was $25 or $30 and we didn't pay any attention to it. It was a better place to buy it than someplace else. But once it was free, just like those houses, once it was free then everybody wanted it. What did they want? They wanted the right to go to whatever doctor they pleased, whatever hospitals and stay there as long as they want, have the miracle cure. They wanted the right and they got the right to smoke themselves to death and be rescued by an artificial heart. They got the right because they demanded it. In effect, to drive a car without a seatbelt and when something happened to them they smashed their brains in and somebody would take care of them. Mine was the first generation to believe it has a right to get sick. We really have been

brought up that way. If you go to the hospital, your employer pays for you to go to the hospital, people send you flowers, they come and visit you and all that sort of thing. If you stay at work then you have to work for your money and nobody sends you cards and nobody thanks you for staying at work. The whole generation has been brought up to believe that.

And so we wonder why the average price of a day in the hospital goes up from $15 a day up to $500 a day. Why do we have too many doctors? Why do we have too much of this? Why do we have too much of that? It's real simple, it's real simple. Because we deliberately set up to do good, not to do evil. None of this was by design. The whole notion of it was to make sure that I never would have to go without. Well, I would have a roof over my head and I would have a doctor and a hospital available to me, and I would have food on the table and good schools and education. But they overdid it. They really overdid it on the notion that I could go through my life and continue to play off of somebody else.

Now, we are all complaining about liability insurance, boy I tell you we are. And health care is called malpractice. And it is going up and up and up. The other day a hospital administrator called me about a woman who came in 55 years of age who had cardiac arrest. She was in

intensive care and her husband was bringing her her cigarettes -- bringing her her cigarettes up there in intensive care. She is puffing away like this. Finally they took her down to Houston where DeBakey gave her a triple bypass and she died. So, they sued Houston Methodist and they used this other hospital, and of course the hospital settled. And the administrator said to me, "Senator, why in the world do I have to pay for self-inflicted injury?"

Now, I am not a reformed smoker, although I will tell you I quit, and I am not trying to be preachy, but I am just trying to illustrate what it is we have been going through during the course of this generation. In order to get your health in the process of how we pull out of it and where we're heading in the future.

Balancing the federal budget cannot be put in the hands of people who have been born and raised and educated to believe you don't have to balance your budget. I mean you send Wendall Ford and Dave Durenberger to Washington to balance the budget and they have never learned to balance their own budgets at home, you are expecting the impossible. And sending any one of you to do the same thing is expecting the impossible, because you don't really believe deep down inside that anybody has to live literally within their means.

Now, I don't mean it either that literally every dollar spent equals every dollar had. But you have to understand that there is something in the head up here that has changed over a generation or two in terms of our attitude. And that is one of the problems that is plaguing us now as we go into this battle on tax reform and all that sort of thing. What in the world is a tax code? A tax code is either a way of raising revenue or a combination of a way of raising revenue and recognizing that by not raising it from certain purposes that you are providing at least a signal as to how we'd like people to spend money.

The national government in the last thirty years has switched from taxing wealth or property to taxing income. That's where we are now, we are taxing income. We tax payroll tax at $6,000 per person per year and that is going up to $8,000 per person per year for a social security system that is $7 trillion under budget today. But there it is. On top of that we have you put in unemployment comp taxes and workers comp taxes, so it is like a damn big mountain without any exemptions or exclusions or anything. But there it sits, a mountain 8,000 miles high just for social security, and that is the payroll tax.

And right next to that we come along with the income tax. We are going to tax the rest of your income away with an income tax in this country. So, with a 70

percent rate or a 91 percent rate like we used to have in this country we realize that people earned income for some very specific purposes, and that if we too literally took this high rate against your income they'd quit working. So, we created what we call differences or preferences in the tax phase, because we recognize that the first reason people work is to put some food on the table and a roof over their head and all that sort of thing. So, to make sure that people have roofs over their heads we have created interest deductions and tax deductions and so forth. Then we realized that people worked so that they would have some money for rainy days. So, in order to make sure that people provided for their rainy days, we had to have certain kinds of pensions and savings and so forth incentives built into the code also.

Then we realized that people also worked so they could invest in the guy next door who makes widgets, and they can sit on their butts and the guy next door does all the work and they can make money off of his widgets. So, we create certain incentives, investment tax credit and all of those other kinds of things as incentives so that people would go and invest money.

Then we also realized that people also have to buy fire and police protection and the street for their house and parks and education for their kids. Where do you

buy that? You buy that from the state and local government; right? So, we created a tax deduction for state and local taxes. I can go on and on.

In America you always have a recognition for those of us who have the capacity to earn more or share that with our neighbors who are less fortunate. So, we created the 501 for your charitable exemption. Now, the President says that it is more valuable to get the rates down to practically zero and let's broaden the base of the tax system. That is what we are up to right now.

Tax reform in America today can best be illustrated by HR-3838 which is the House bill. In case none of you have seen it, here it is. I don't know how many of you have seen this bill. It is a real dandy, it weighs four and a half pounds and has 3,960 pages, the thoughtful person can read it in about 46 hours assuming you want to understand it. It takes about 46 hours to do it.

But I can illustrate it quite simply. Last year George Bush who made more money than I did was in a twelve and a half percent tax bracket and I was in a forty-five percent bracket with less income. What this is is an effort to get George up to twenty-five by promising me I can come down to thirty-five. That's in essence what this says. George doesn't like to hear me say that, but that is the reality. Broaden the base. George has got lots of

investments in Houston in apartment buildings and commercial office buildings and apparently those of you from Texas know Houston and what that means. So, the big losers he gets to write off a lot of stuff and so he has got a twelve and a half percent base. So, we are going to broaden that one out so that Dave who was in a forty-five percent bracket can be brought down to the thirty-five percent bracket. That is the best way that I can summarize what it is we're up to. Again, I am not knocking him. I am just telling you that that is what we are up against. And if you think that's the way we ought to do tax reform then you ought to try to be more helpful to us than you have been, individually or collectively in the past.

Now, I am going to end this by answering a question or two, but in case you wonder what would be an ideal way to do tax reform, let me suggest it to you. That is as far as the national government is concerned, it ought to recognize that we have learned a lot about spending and we have learned a lot about saving and we have learned a lot about investing. In fact, the folks in this country are probably a lot smarter than anybody gives them credit for being. Now is the time for putting the federal income tax in neutral on the issue between consumption, investment and savings; at least the minimum of neutral. Put it in neutral.

And one day to do that, of course, is to take the income tax and just let people know that you are not going to tax savings investment. Current income that goes to savings investment is not taxed. When it comes out of savings investment and is consumed, then it is taxed. That is the only simple rule you have to have in your income tax. If it's savings, then you've got to identify what savings investments are and we could argue over that a little bit, but that would be the rule. And the stuff that is consumed today, that is taxed.

Explicitly, however, you can go and you don't have to do just that. That would be sort of the neutral way of doing things. You go beyond that to an explicit consumption tax like a sales tax or value added tax. Today a ten percent value added tax across the board, no exemptions, but with refundability built into the bottom of it for lower income people and translated right into the income tax withholding bracket, would raise about $220 billion. Now, that would buy a lot of rate reduction. If you want to reduce your income tax rate, that would buy a lot of rate reduction. If you want to reduce or put a cap on your payroll tax, that would buy a fair amount of Medicare and social security and so forth.

I suspect the American people if given their preference today would like to move in the direction of

putting the tax code in neutral. It would also like it to move in the direction of simplicity and so forth. But if they watch us try to broaden the base like this, if they watch us another year doing this sort of thing, I doubt very much whether they're going to think that the George Bush/Dave Durenberger theory is the best way to do tax reform. And they'll assume that somebody loses someplace for all the folks that allegedly gain, and nobody in the tax system gains for very long. Even though Dave is brought down to thirty-five, I think people would find it hard to believe that I would stay there.

So, the debate will go on for some period of time. In the next few weeks we will try to finish mark-up in the Finance Committee. I suspect by the end of this month or whenever we finish we will be at about a thirty-eight or thirty-nine percent rate. But at that point the President will have to decide whether he buys into the thirty-nine percent rate, and that's tax reform or not. So that, I think, will be the history of the tax reform during the course of this year, but it won't be over with until we move in the direction of a consumption tax in this country.

So, I want to alert you to some of the things that I am going to do this week on installment sales and on capital -- installment sales becoming -- I don't even know if you've focused on this, but Packwood has some new rules

on uniform capitalization where you are going to have to capitalize all of your tax depreciation, pension, fringe benefits costs and a portion of your general administrative costs in connection with inventory. I am going to try to knock that out during the course of the week. You might take a look at that. If you don't like it, let me know. I would appreciate whatever support I can get on it.

Thank you very much Dan and thank you very much for coming all the way down here. Mabel, I know it is snowing and the ice hasn't left the lake so you can't do anything up there anyway. Thank you very much.

(Applause.)

Since I was so vague in my speech, maybe somebody has a question they would like to ask.

Are you going to ask a question or are you in charge of the microphone?

VOICE: No, but I will answer something for you.

VOICE: Senator, one of the things you did mention was that the top corporate rate might go to thirty-eight or thirty-nine percent. What else do you forecast, or what do you contribute the reason for that rate? And what do you see happening in the area of capital profit recovery and those things?

SENATOR DURENBERGER: When the Republicans in the House last December told the President they weren't going to

support this, the President said why, and they said because it is anti-capital formation. So, the President said well if that's all then don't worry about it and I will have the Senate take care of it. So, the Senate is now in the process of taking care of it. I mean, we are not going to permit, by varying degrees, we are not going to permit the sort of selective dismantling of what the whole part of the tax code that are to the advantage to capital formation, especially those of us who come from high cost capital parts of this country. So, we will be in the process of not closing up the recommended tax preference area, and it is that refusal to go along with some of those sort of things that will get the rate I think not to come down below thirty-eight or thirty-nine percent.

I know you are very interested in the investment tax credit, and I think that is one of the victims on anybody's schedule if in fact we are going to get the rates down, the investment tax credit is on everybody's list of areas that are going to go. Because, in effect, they go across the board and touch a lot of people who are in the capital investment business.

Now, some of you may -- a lot of you won't remember this -- but I was the father of the refundable investment tax credit, and then in 1981 of safe harbor leasing. So, I am not the first one in line to get rid of

the investment tax credit, because as long as there are ITC's, I have been the one to find creative ways to spread them around so that everybody gets to use them. But I also recognize this year that if you're going to use the base to bring down the rate, then you cannot eliminate the ITC's. This is inevitable. The question then becomes what happens to earned income tax credits, investment tax credits. You can cash them out like Bob Packwood suggests or credit them against alternative minimum taxes or something else.

The alternative minimum tax is the hardest thing for us to deal with, because that is really an oxymoron. Everybody in the country says we ought to get all of these corporations that don't pay taxes. Well, the only way you do that is to defy the laws of income gravity. And that is that people do not -- most of them don't, at least in this room -- do not earn income in twelve month increments. Our income sort of goes like that during the course of a lifetime. And if you come slicing through there with a twenty-five percent minimum tax and you catch me in a down year and you make me pay up here, that just ain't fair. So, we are having our hardest time with that alternative minimum tax issue. What should be a tax preference for purposes of alternative minimum tax? I think we will have a less difficult time with accelerated -- I think you will find our recommendation on depreciation for attractive.

What we're debating are issues like indexing, and 200 percent versus 150 percent, depreciation schedules and all of that.

Did I miss something else from your question?

The gentleman in the back row.

VOICE: Senator, what is your feeling on the Graham-Rudman Act?

SENATOR DURENBERGER: What is what?

VOICE: The Graham-Rudman -- what is your feeling about it?

SENATOR DURENBERGER: What's my feeling on Graham-Rudman-Hollings -- let's not let Fritz off the hook. I am all for it. I have been here since 1978. I was elected to balance the budget and I haven't been able to do it. The federal debt was $650 billion when I got here, and it is $2.1 trillion today. And Ronald Reagan says take it all out of domestic spending, and the rest of us say take it out of defense. Hell, we are not having the choices. We are all going to stand around here and be 536 experts on how to balance the budget, and nobody gets the job done. Well, we need something to help us do it. We tried it last year in the Senate on May 10th, right about this time, a month later, we passed the budget resolution that froze social security and froze a bunch of programs and things like that. It passed by one vote. George Bush cast the deciding vote,

the first time he ever cast one of those votes on something other than chemical warfare, and he was very proud of it and justifiably so.

But then we took it to the House and the House said put in $31 billion of new taxes over three years and we'll support it. We took it to the President and he said I will not support any new taxes. At that point -- Now, we would have had the budget balanced in 1990 on our resolution. When that failed, we went back to the drawing board and Phil and Warren and Fritz came up with the Graham-Rudman-Hollings. Now, it's failing its first test right now because the Senate Budget Committee came up with a deficit reduction down to $144 billion, which is our goal. The President said, I will not live with it because you have made the sixteen cent cigarette tax permanent which I decided I would go along with, but I don't like you to use taxes to come to your $144 billion. I want it all to come out of spending. And he said, I don't like the fact that you reduced defense spending down to real growth with no increase. So, now we are hung up again debating it. If we don't do anything it will automatically happen in the fall, and if it automatically happens and it hurts the farmers, and it can hurt Medicare and can hurt a lot of other things. But damnnit, I guess it has to happen, and somebody just has to kick the mule in the head a couple of times for it to get

it to happen.

VOICE: What's the outlook for the provision to take away the deduction for the excise tax?

SENATOR DURENBERGER: What is the outlook on the excise tax deduction? I think it's pretty well dead. I told Bob right away when he briefed us that I was against it for a variety of reasons. One of them is because I am also against eliminating deductibility of all state and local taxes period. Plus, the unfairness between industry, the unfairness between country businesses versus city -- I can go on and on. There is a whole long list and Wendall probably wouldn't approve when he was here earlier. So, I don't think he's got the votes of the Finance Committee to pass it, but what he's going to do is take this rate down to thirty-nine percent illustration and say, now, you can get it down to thirty-six if you went for an excise tax. And he'll turn to Ronald Reagan first and say, if you can come out with the excise tax we could have a thirty-six to a thirty-five percent rate. The President I don't think would support it because in effect it's a new tax. If you eliminate that deduction you are imposing a new tax. And it is an unfair tax. It is just not a fair tax. I don't object to new taxes once we get some of this spending in line. But if we are going to do it, like I said earlier, the sales tax or value added tax or something like that across

the board on everybody and all that sort of thing, that's okay. But when you do it selectively, like this does, that's not fair and should not be supported and I don't think it will be.

VOICE: (Inaudible).

SENATOR DURENBERGER: The question is about the rural crisis, and I think that's a better way to put it than just farming, because the problem is really a problem of rural America. And it's a combination -- those of you who have got groceries in small towns know that it's a combination of what happens to farm price income and farm value. In our southern tier counties in Minnesota we were averaging in '81 $3,000 an acre. Today it is about $800 or $850 or something like that. So, it is like taking your $100,000 home and ending up with only a $30,000 home and a $75,000 mortgage. But, anyway, that ripples into town. That is one part of it. That is a very serious part of it, because those farmland values are not going to get up very high if they ever level off. A lot of businesses in town are gone. Most of our counties are losing a business a week on the average, except in the dairy areas where the dairy prices are still standing.

But the second half of that problem is deregulation, and deregulation and centralization. With the market literally at work in telecommunications and

transportation and health care and a lot of other things, the cost of delivering services in areas where populations are spread out are going up per person, because the market says you don't subsidize any more, you don't hide subsidies. You don't hide the telephone subsidies in the country inside the long distance charge. You can fly from New York to Los Angeles a lot cheaper than you can go from Rochester, Minnesota to Moline, Illinois. We're going to the marketplace. That means small towns -- it costs a hell of a lot more to deliver those services. That is just a couple of examples of why long term -- plus you take iron ore and steel and shoes and textiles and all of the industries that in effect are dying from foreign competition, and again from a marketplace in which we're letting American become a bazaar and letting anybody come in, that is creating a problem for rural America too.

What a lot of us are starting to do is to get the attention of people on that side of the issue so that we at the national and state government levels can look at it that way. Not saving farmers. You know, we can't save about forty percent of the farmers. They are gone. Half of them are gone and the other half will be over there in two years. We have got to do something about saving rural in America. I don't have the answer how to do it, but I am just trying to identify the problem.

Yes?

VOICE: Senator, what are your feelings concerning giving the President line item veto?

SENATOR DURENBERGER: What are my feelings giving the President line item veto? The answer to that is -- the argument is made that governors have it and they use it effectively, and I agree with that. So, if we have a constitutional amendment to balance the budget, so the President has to balance the budget every year, then I'll vote for line item veto. In advance of that, I will not vote for line item veto, because he will only use for Nicaragua or something else, or like the food stamp bill. I couldn't get a lot of help from the Administration, let me tell you on that one.

It just happened because a grocer friend of mine from Rochester, I was on the phone talking with him about something else, and he said, "Well, while you're on the line, I have another complaint about the federal government." He said, "You're letting the banker charge you six percent on these food stamps, and I have to collect the food stamp money from all of my customers and I have to bundle it up. I take it down to the bank in bundles. He doesn't have to do any work at all and he is charging me six percent." I said, "Hell, Dale, that's unfair." So, I put the bill in. I couldn't get any support from the

Administration as you well know. Then I had some trouble with Jesse Helms, but it is now in there.

VOICE: Senator, if we understood that we are going to lose investment tax credit, are we taking a tremendous gamble in losing the initiative or growth of our country?

SENATOR DURENBERGER: Yes. I think it is true that there is a period of gamble, because the cost of capital in America even with interest rates declining as we have now, which is not necessarily reliable. We are all afraid that if it continues this way -- but it may not be all that reliable. But the capital in this country is still high compared to the cost of capital in other countries. And that is -- you can just forget about tax breaks and things like that. It is just the actual cost to you of making an investment. It is at least twice the cost of a counterpart in a lot of other countries, which means they can get on this market a lot cheaper. But it would appear, at least for the time being, the President at least is willing to take that risk. You know, the guy has been so good by being so optimistic about things that a lot of people are inclined to say, well, let's take a chance at it. But those of us who represent natural resource base industries -- for example, not to leave you out of it except that you wouldn't be in business if it weren't for the

farmers and a lot of other people. So, you are in this issue.

The heavy investment that is required in agriculture, foreign products and mining in this country is huge and enormous. If we let those businesses or that investment disappear, then we will never get it back, we will never get it back. It costs so much to bring it back and to make those investments. But we are not ready to deal with that yet. Yes, we know we are taking a risk. Is anybody thinking it off here in Washington? No, nobody is thinking it off. And somewhere over the next four or five years we will debate it, maybe in the '88 election. We will debate just exactly the question you raised. But those things are never resolved in an election.

Is that it?

Okay, thank you very much.

(Applause.)

VOICE: Senator Durenberger, thank you so much for joining us today. Before you leave Tom Zaka (phonetic), NGA's president and Ben Copern (phonetic) have a special presentation.

VOICE: Senator, an outstanding presentation, as always. And it is an honor for us from the National Grocers Association to present to you this afternoon the Spirit of (inaudible) Award, presented to the Honorable Dave

Durenberger in recognition of outstanding leadership in the United States Senate, for sponsorship of legislation prohibiting bank charges on food stamps, for commitment to assuring fair and equitable administration of the nation's food stamp program, and for a career of public service dedicated to preserving free enterprise in the independent center of the food distribution system. April 9, 1986, Washington, D.C. Thank you, Senator.

(Applause.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

SPEECH TO

NATIONAL ASSOCIATION OF HEALTH LAWYERS

May 7, 1985

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MODERATOR: So it is my honor to introduce Senator Dave Durenberger of Minnesota.

[Applause.]

SENATOR DURENBERGER: Thank you very much.

It's a pleasure for me to be here, and particularly a pleasure to get that introduction from Mike. I am sure that many of you did not know that the United States Senate would have a committee on intelligence.

[Laughter.]

SENATOR DURENBERGER: It really comes as a surprise to know that last year I was not only on the Committee on Intelligence, I was on the Committee on Ethics.

[Laughter.]

SENATOR DURENBERGER: There is one of those, too.

[Laughter.]

SENATOR DURENBERGER: Well, yesterday I was honored by being asked to speak to the Economics Club of Detroit, and lest that imply that I am an economist, I was speaking with Joe Boyle from the AMA and with Jack Cohen from the American Hospital Association, but none of us is qualified to talk about any kind of economics, including medical economics.

I am going to talk to you today about overt

versus covert, and that's the first time I've heard it put that way. I love it. And I want you to know that, in the words of some famous humorist, today, "I am here from the government and I am just here to help."

[Laughter.]

SENATOR DURENBERGER: If you believe that, you'll love me in the morning.

[Laughter.]

SENATOR DURENBERGER: The latter part of the speech literally is about, "The check is in the mail."

[Laughter.]

SENATOR DURENBERGER: Some of you have heard me speak before and it probably hasn't changed a whole heck of a lot, so the interesting part of this conversation will be in the Q&A.

I need to scope out what we say about health care in order to enable you to be part of this process. Maybe you're just here because we're making a good business for lawyers now that we're going into competition and using the marketplace. We all know the problems of the marketplace. Nobody can venture in there without a lawyer. Or maybe you're genuinely interested in health policy.

I walked down the escalator and I saw such things as "Medical Malpractice," and what were some of those other interesting signs? It sounded like the world was coming to

an end.

[Laughter.]

VOICE: "Troubled Facilities."

SENATOR DURENBERGER: "Troubled Facilities."

[Laughter.]

SENATOR DURENBERGER: And "The Minefields of Antitrust."

[Laughter.]

SENATOR DURENBERGER: It's just a lawyer's dream.

[Laughter.]

SENATOR DURENBERGER: I wish I were back practicing again. How can you get through the minefield of antitrust to a troubled facility --

[Laughter.]

SENATOR DURENBERGER: -- without your handy lawyer who belongs to -- what is the name of this organization?

[Laughter.]

SENATOR DURENBERGER: See, it's the solar-powered calculator [inaudible].

So let me presume that you don't have a selfish interest being here and that you are willing to be helpful to us as we try to address the appropriate role of government in the area of health care.

So I have to then put all of this in the larger

perspective of what is going on in the country today. Let me start at the beginning by saying that the fact that I love my President, I am a very good Republican, and if I say anything that doesn't sound Republican, you've heard wrong.

[Laughter.]

SENATOR DURENBERGER: But as I searched for a theme for what I am going to say, I have to quote Gary Hart, who is not a Republican, at last count. Gary Hart made a little speech to the Democratic Party the other day. And as you all know the Democrats are all talking to the Democrats about what Democrats ought to be. Unfortunately only Republicans are listening.

[Laughter.]

SENATOR DURENBERGER: But Gary had a one-liner that I caught in a Washington Post headline, before I went to read the Washington Times about how you can all contribute to the contras in Nicaragua.

Gary said to his party, "We ought to concentrate on old values, not on old programs." And I will swear that if I keep repeating it often enough or if somebody will pick up on it, that that will be the theme of the 1988 election.

And until this country actually deals with the old values and gets off of its kick of trying to beat up on the old programs, we really are not going to have a genuine economic recovery, political recovery, all of the sort of

things, the "shining city on the hill" and all that sort of thing.

My great fear in a political sense -- this is the only political thing I will say today -- is that Republicans will spend, as we are this year right now -- I have to rush back to make the end of the caucus and get my marching orders -- we will spend the next three years beating up on old programs while the smart Democrats are out there building something new on the old values. And in the period of time beyond the 1988 elections this country will be dominated, in larger part, by Republican politicians.

So that is a concern that I have, and I have to keep saying it. Maybe some Republicans will hear it, the kind of Republicans, for example, that believe that the only spending that is bad is the kind of spending that I do.

The kind of spending that Bob Dole is trying to lead us into, a $300 billion over three-year reduction of, it is: Medicare, Medicaid, $600 toilet seats, $100 light bulbs, $700 illuminated toilet seats -- all mixed together, all mixed together. Medicare, you love, Medicaid you love; you need more of them. $600 toilet seats you don't.

But how to distinguish, when we hear such things as, "We all know the answer to a government that is too fat: Stop feeding its growth."

Sometimes the big spenders in Congress talk as if

all that money they spend just kind of magically appears on the doorstep, they get it from the IRS. They talk as if spending were all giving and no taking. Government spending, that is the real [inaudible].

Now, if any of those lines sound familiar to you, they came out of what I thought was about the best speech I have ever heard a President make, a week ago last Wednesday night. But on the premise that is made in that speech, I predict that the Democratic Party will be the majority party in this country in the period from 1989 on. If we spend all of our time tearing down government by focusing on one part of government spending, we are going to be in trouble.

So today I am going to suggest to you that there are four other things we ought to understand about spending which is in one way or another facilitated on behalf of society by government, and start with the premise that government is never ahead of the people of this country, it is always behind the people.

We have never invented anything in this town. Never. I don't think there is a soul in this room that could prove to me that something that became national policy started inside the Potomac. It didn't. It doesn't. It never can.

[Laughter.]

SENATOR DURENBERGER: Bill Gradison says that

this is the only city in the country in which sound travels faster than light. And that's true.

[Laughter.]

SENATOR DURENBERGER: It's true.

We are, have been, and always will be several years behind the rest of society in this way. And it doesn't make any difference whether it is the Congress or it is the judiciary, it is always that way. It is always that way.

The President and I had a little argument a couple of years ago when I went up to Baltimore and characterized one of the premises for his new federalism -- not his new federalism -- as, and I used the word "baloney," and I regret using that.

[Laughter.]

SENATOR DURENBERGER: He called me in the Senate dining room at 8:00 the next morning and he was very angry.

But his thesis is that over the last 25 years, maybe more, maybe since the New Deal, the Federal Government has gone out usurped the power, the authority, the imagination, the creativity and the compassion of State and local government and the private sector, and it has sucked people's income into Washington to be returned to them in the form of compassion and innovation and categorical grant programs and regulations and so forth.

My theory is quite the reverse. My theory says, in effect, that the compassion was there but the capability was not. Local government was dependent totally on the property tax. State governments were afraid to explore sales and income taxes. Legislatures were dominated by rural interests. There was no professionalism. Even in a great State like Minnesota, the legislature met for 60 days or 90 days every two years. Now, that is probably what they ought to go back to but --

[Laughter.]

SENATOR DURENBERGER: The fact of the matter is that it was people in need who came to this place with solutions invented in the Minnesotas and the Californias and the New Yorks and you name it, and they created the income tax and inflation to help -- and the categorical federalism -- to help satisfy those needs.

So it is important to make your decision on this issue of devolution and responsibility. You are either with the President or you're with me on this issue. You cannot do this one both ways. You either start on the assumption that the Federal Government is a servant of the people and it's the last resort that you go to only when you have to, or you start with the presumption that everything the Federal Government is bad -- except defense and debt -- and therefore we ought to eliminate it all. And today there

isn't a lot of in-between any place as we approach these issues.

Now how to approach the issues. The President is on the right track, not necessarily in his articulation. And that was demonstrated not by me but by the fact that there wasn't any positive reaction to that speech. It was a nothing reaction. And it was the best -- I mean without doubt; I have passed it around and let you read it -- it is the best political speech ever. Ever. If you want to believe that this place is fat and overcome with whatever it is, you want to believe all that stuff, this country should have risen up, because it was very carefully crafted.

By last count, in most offices -- at least north of the Mason-Dixon Line, where they pay taxes --

[Laughter.]

SENATOR DURENBERGER: -- it was the negatives were running like 3-to-2 ahead of the positives on this really great speech. And on that speech is premised lower taxes. On that speech is premised the balanced budget. On that speech is premised economic recovery and turnaround. I mean everything that anybody could want in this country is in this speech. But it's getting a 3-to-2 negative over positive reaction.

So I would suggest to you that we need -- including the President, and he is going to do this the

minute he gets off the plane from Europe -- we need to start expanding our concept of spending. We are doing it in the health business, all of us, and we have been doing it for some period of time. Now we need to get everybody in the same act.

The first kind of government spending is when you take the taxes and you appropriate them for particular purposes. And we have already talked about Medicare, Medicaid, highways, and all that sort of thing [inaudible]. In it is some sense of national purpose, but it's usually hard to find. $650 million appropriated for a national rail passenger system is bad, according to Dave Stockman and the President, in this speech, because it costs $35 per ride to maintain that system for those who aren't regular users of them.

However, $14.5 billion in one year for new highways in America is a good. And I don't know how much, maybe $12 billion a year in interest deductions for new automobiles is a good.

Add it all up and it is probably a $30 billion, $35 billion commitment if you add in the fat health insurance plans as GM and Chrysler and Ford, probably $35-40 billion in spending to maintain the automobile, against $650 million -- puny, little investment -- to try to incent the growth or regrowth of the national rail passenger system.

But have you ever heard anybody talk about that issue? Of course not, because we are in the business of getting out of a lot of lines of business because we believe the Federal Government should not be in a whole lot of businesses.

Now, when I use interest as an illustration of spending, I want you to know that if we froze tax spending in America today, we would save 50 percent more than if we froze government spending. A freeze on government spending would save about $31-32 billion if we froze fiscal '86 like fiscal '85. But if we froze all of our tax expenditures for '86 in the '85 amount, we would save $46 billion. A lot of dough, when my interest deduction and your ACRS and Lord knows what else.

But are we likely to do that? No. But it is very important that we understand what we are doing. $424 billion in tax spending will be our individual and our corporate contribution to the debt next year. So it isn't just the toilet seats and it's not just Medicare, Medicaid, and so forth that contributes to a $225 billion deficit. It is $424 billion in tax spending that also is part. If you're building your Washington Monument now with me, you start with the direct spending, now you've got $424 billion in tax spending.

There was an ad in the Wall Street Journal in

December, sort of one of those year-end tax ads from Cessna Aircraft, that said, "Two reasons to buy a Cessna single-engine aircraft." And I don't know what the second one was because the first reason said the IRS will give you all your money back. And they proved it. The ITC, ACRS, the interest deductions, your [inaudible], you got all your money back from the IRS.

Well, here is Ronald Reagan saying -- this is the second paragraph, top of page 2 for those of you who are reading along with me.

[Laughter.]

SENATOR DURENBERGER: Sometimes the big spenders in Congress talk as if all that money they spend does kind of magically appear on their doorstep, a gift from the IRS. Well, of course we think it's a gift from the IRS, because Cessna tells us, everybody else tells us, "You can get your money back from the IRS."

And you folks know, everybody in this room does it around just before April 15, we all sit down, we get out our, not our own checkbook, but the one we have been given by the Finance Committee and the Ways and Means Committee. And it is all a checkbook drawn on the U.S. Treasury. And we sit there until our return is done, you know, and we write out these checks on the U.S. Treasury.

I did it this year because I bought a second-hand

Olds Cutlass Sierra. With the sales tax in Minnesota, it amounted to $9200. So I went to my banker and I said, "Borrow me $10,000." That's the way we talk in Minnesota. "Borrow me $10,000."

[Laughter.]

SENATOR DURENBERGER: Well, he said, "How long do you want to pay?" I said, "I want to pay nothing but interest." And he said, "Okay, you've got five years, nothing but interest."

So every April 15 I sit down and I write out a check that is drawn on your account at the Treasury. And after five years you will have bought me a second-hand Olds Cutlass Sierra.

[Laughter.]

SENATOR DURENBERGER: But you all do it. We all do it. We all do it.

George Bush, I brought this issue up with George Bush right after April 15, and I am in the 50 percent tax bracket and he's in the 12.5 percent tax bracket.

[Laughter and applause.]

SENATOR DURENBERGER: Unfortunately for George, he only made $20,000 more than I did last year.

[Laughter.]

SENATOR DURENBERGER: At least that's all he claims.

[Laughter.]

SENATOR DURENBERGER: And the year before it was 13.5 percent. And I said, "George, how did you do that?" And he said, "Well, I got a losing apartment house in an apartment building in Houston."

I said, "George, tell me then how do I go home to Minnesota and explain that apartment buildings in a community that is $20 billion overbuilt already is a better investment of the taxpayers' dollars, with a $225 billion deficit, than oil conservation, preventive health care, cap on Medicaid, making beneficiaries pay more, lying to the hospitals about the fact that we were going to give them a CPI? Hey, George, I mean, see the damn apartment building. At least you know what a hospital looks like."

[Laughter.]

SENATOR DURENBERGER: "You know what a poor person looks like. You know that the biggest killer in America of children last year was: poverty. Poverty. George, do you know that? Now do you want us to put all this money into your apartment building in Houston?"

Well, of course we'd like to have it both ways. We certainly would. And in America we are going to find a way, hopefully, to have it both ways.

But we are presented with a proposition that is an either-or, because apartment buildings in Houston are

today more important than 10,000 little kids.

I could not believe the head of OMB when we sat down and I had to tell him -- tell him, in effect, threaten him -- that I was thinking about changing parties or something if he prevailed with the notion that Republicans could advocate taking money away from the Medicaid program in a year like that.

So that is not just politics, boys, I mean that is trying to deal with the reality of how we spend money and allocate resources in America.

Now, those are two big tickets: $950 billion we spend on toilet seats, Medicare, et cetera; $424 billion we spend on Olds Cutlass Sierras and Cessna airplanes and apartment houses in Houston.

Now, what else do we spend? Well, the most famous spending of all I think we are probably over. The most famous spending of all, of course, is having today and sending the bill to tomorrow. In my generation it was the $500 home in the suburbs [inaudible] undesirable neighbors and with low property taxes and good education and free health insurance and a new car every three years or something like that.

I was promised by my folks' generation when they were in charge of this country that I could have what they never could have, and that is: a home of my home. I could

have it for $500 down, forever to pay, four to five percent interest rates, all deductible.

I was one of the generation of people who had stood up with our $500 voucher or whatever it was and said, "I want one." And believe it or not -- well, you wouldn't find this hard to believe -- more people stood up than there were houses. So what happened? Well, we had to get more houses. How did we get more houses? Well, we paid the contractors more, we paid the construction workers more, we paid the lumberman more and everybody, and we kept paying them more so we could get more houses.

And of course, the folks who already owned houses were really the ones who were sitting in "fat city" because if they had paid $10,000, now it was worth $15,000 because everybody was waiving their vouchers for $500 or their checks for $500 and willing to buy it.

That is an old story. Most of the folks in this room have lived through it. Some of the folks I see in this room are going to pay for it because some of the people I see in this room can't afford to buy the home that for me 15 years ago only cost $10,000.

Now, we did the same thing with health care, and this is where we created inflation and all that sort of thing. In health care it was group-rated employment, executive employment, purchased health insurance covered by

the tax code. Business deduction to the buyer and tax-free income to the consumer.

So everything under the sun that was related to health care, including swimming pools if you had a bad back and, you know, you name it, health foods, everything showed up in America's version of health insurance. And it was all paid for by the taxpayer.

Wonderful system. What did it do? It created a generation of people like me who do not care about their health because there are no consequences. In fact, the system works in reverse. The way I was taught is that it is good to be sick and fat than stay healthy because if you're sick you get free time in the hospital courtesy of your employer. They will continue your pay. You can have sick leave. Everybody will send you flowers. The boss may come to visit if it's serious enough. These people will call your wife and say, "Oh, we miss so-and-so," and so forth and so on.

But if you stay healthy, they make you go to work.

[Laughter.]

SENATOR DURENBERGER: What kind of a system is this? They say smoke and we buy you an artificial heart, like we did for Barney Clarke, 25 years, 2-1/2 packs a day, he got $205,000 out of a bankrupt Medicare trust fund for an

artificial heart, extended his life for four months.

We all know this is our system. How did we get it? By wanting to have today regardless of the consequences. So we raised the price of hospital days from $10 a day to $1000 a day. We've raised the doctors from -- you know the litany, you can make it up yourself, you know. Just like we did on the houses, we did it in health care.

So that's a third way to spend money.

There is a fourth way to spend money in this society that the consumer to spend that you are also familiar with in the health care area, and that is: regulation. I won't bore you with all the details on environmental regulations and OSHA regulations and this regulation and that regulation because all of you as lawyers know these things and you know how the public interest is served by creating costs to the producer of the goods and services.

The fifth kind of spending I call the sort of anticompetitive restraint-of-trade or "keep the good guys, the new guys, out of your plot." In automobiles, we did that in 1981 because of the threat of having to buy quality cars rather than chrome in America became too much for Detroit to tolerate; not only Detroit but Missouri and other places.

So we said, "How can we handle this one? How are

we going to keep the American automobile industry from being destroyed on its $23-an-hour labor costs, its 11 percent capital costs, and its unwillingness to build a good automobile?"

We said, "The best way to do it is to keep the good automobiles out." And so we went through the voluntary quotas; we kept the Japanese out of the market, except we let in their best cars which we all paid $3000 more for than we should. But even on the American cars we paid $2000 more today for an American car than you should pay.

Everybody, all of you, get it legislated, no Senator voted for it, we're all free, we're off the hook. You got stuck for $2000 a car. You saved 44,000 jobs at $23 an hour. It costs you $165,000 a year for each of those jobs you saved.

Now, is that -- I don't want to go back and quote the President again because somebody in this room is going to report me to him -- but if that isn't fat, I don't know what is fat. But that, too, is government spending.

In the hospital business, you know what that is: That's New Jersey, Massachusetts, New York, and Maryland, so far, and maybe some others right behind them. It says freeze it in place and don't let the competition in; we can't afford to let the subsidies for the poor and for

teaching and for inefficiency be exposed.

That's just like the automobile industry: Don't let the competition in. Don't let quality in. Don't let alternatives in. Don't let efficiency in. Don't let anything in, particularly don't let price as an object for a purchase get in this one anywhere because if that happens then some politician is going to have to stand up and be accounted for his responsibility in not financing the indigent explicitly.

Some other politicians and some people in medical specialties are going to have to stand up and say, "Why do you put so much education into those doctors when they probably don't need it? Why do we have hundreds of medical specialties that we may not need?" We don't want the public asking questions like that, do we? So, keep the competition out, let's not put a price on anything, and we'll just automatically raise the price to the consumers in Maryland and New Jersey and New York and Massachusetts so that we don't have to deal with those problems.

That is another way to get us all to spend money: the cross-subsidies, maintain the cross-subsidies; guard the long-distance telephone call in order to get the phone service out in the country. Charge the long-distance airlines for the few people traveling between the small towns. We've done it in our society for a long time. Today

we can't afford to do it.

So with that kind of what I hope is still a broad perspective on spending, I would invite you all to sort of consider or reconsider your involvement in the political process here in Washington.

We started to play the government's role two years ago in changing the way we finance Medicare and eventually maybe Medicaid, put prospective payments to hospitals. We hope as soon as we can to make that a more sensible payment system, but it's only temporary as we work our way towards the beneficiary purchasers of private health plans in what we call the competitive medical plan market.

In the meantime, we hope to expand that system to include all providers, including the doctors. It does not mean we will have GRDs for doctors. We may have relative values [inaudible] something else, but we will expand the prospective payment system because it's a smarter way to buy.

Along the way we have to find the [inaudible]. We have to do something about [inaudible]. We have to try to flatten out the artificialities that exist between various forms of corporate organization. And we have to do something in tax reform, obviously, and make some decisions about whether the kinds of services that are delivered in hospitals qualify for certain forms of subsidized capital or

contributions and perhaps for some other forms of government involvement.

At the same time we are doing that, there is a revolution going on in America in the way health care is delivered. The biggest revolution probably comes in how my choice of health and sickness evolves out of all this. It is my hope that consumer choice in health care means that I have the financial incentive to stay healthy, and the folks that make the choice to ride their motorcycles without helmets, the folks who make the choices to drive their automobiles without restraints are going to pay a different societal price than I make when I strap that belt on every time.

When I buy my life insurance and my health insurance, I better see a nica, big fat difference between smoking and not smoking. And you can tax tobacco all you want, I still don't believe it's much of an incentive to get people to quit smoking. The only way to do it is to put a big price tag on it when you buy your health protection or your life protection.

Well, that is the first element of consumer choice.

The second element of consumer choice, is obviously, how you enter the hospital/doctor market. And today in America more people are entering that through a

choice of health plans. And therein lies the huge revolution that is going to make lots of money for lots of lawyers in this room because some day [inaudible] and in the meantime you're going to get fat on [inaudible] or miscarriages and lots of other screwy things that are going on out there because everybody tries to search for a piece of the market, a piece of the market. Everybody is looking for their piece of the market.

And I didn't bring along all my ads from the Twin Cities, but for those of you who aren't from the Twin Cities, I could just show you out of one newspaper, all the full-page ads that are being paid for by HMOs because the employers can't price the HMO product low enough to force these people to be a little more economical in the way they sell their product.

But they're out there marketing, they're trying to get, you know, a piece of the action. So in there is a lot of business for lawyers until somehow or other we settle on a public policy as it relates to consumer choice.

There aren't any easy ways to get there. I assume the antitrust issues will be big. Then the struggle will be is that national legislation or is that State legislation? Whoever ran the malpractice thing, I wish I had sat there because I have not answered one [inaudible] malpractice and then I see it, you know, I see the

differences.

I was in Michigan yesterday, and the difference in premiums between Michigan and Indiana are incredible, I mean for the same sort of thing. And if we're going to leave all this stuff to the States like we're supposed to, where in the world are we going to end up?

But do I have the answers for it? No. Do I have the answers for any of this stuff that I have been talking to you about? Not really. Not really, except that I know we have to rely on the marketplace. I know that my choice as an individual means I am going to take some responsibility. I think that is good.

Then it's a matter of sorting out the role of government, the appropriate role of government. If you learn anything else here today, my role of government is, in effect, that government is good, not bad. When it gets fat, you need to slim it down, but you don't need to get rid of it.

Thank you very much, and I will be happy to respond to any questions. Or if somebody wants to start an argument?

[Laughter.]

SENATOR DURENBERGER: Yes, sir?

QUESTION: In the little bit of debate [inaudible] budget resolution, do you foresee any amendments

on the Medicare package to alter the freeze or to alter patient copayments or anything?

SENATOR DURENBERGER: No. The $16.3 billion Medicare, $1.1 billion or $1.2 billion Medicaid amendment that came in on the Senate side will probably get slimmed down a little bit on the House side, but I suspect that they will primarily be interested in protecting the Claude Pepper constituency in getting rid of the increase from 25 to 30 percent on program costs on Part B. And they always beat up on the deductible for some reason or other. I still don't understand why, but they do.

I think they will concentrate there. But they may find some other innovative ways to cut into Medicare, but I kind of doubt that they will.

What we did in there, of course, besides the freeze, is we did a carve-out -- we hope that it will be a carve-out -- of the participating physicians in Part B.

We hope to take the indirect medical in education down gradually. Next year would be 9.0 percent instead of 11.9 percent per 1/10th of an intern, however that works. And then after that it would be about 7.4, and then in the third year it would be about 5.79 or 5.8, which is in the third year out there is a 50 percent reduction in indirect.

Within indirect, however, we are going to try our best to get all those big educational hospitals onto the

same playing field.

And I say that because Chip gave me the Minnesota-versus-UCLA comparison, where UCLA is 1.0 and Minnesota is .43. In other words, UCLA has 2.5 times as many interns/residents per bed as we do at the University of Minnesota, so they get 2.5 times as much money. But I don't think per intern they are doing any more educating than we are. So we are going to try to level that one out.

On direct medical education, I can't announce this till tomorrow, but I guess -- I hope -- but on direct we will freeze '86 the same as '85 and then we will go into the Dole-Durenberger-Bentsen graduate medical education amendments, which, in effect, spend something slightly less than $1.125 billion on all of the years of graduate medical education up to board certification. Sometimes that's three years, sometimes it's a little more than three years. That is our proposal.

Also we will take out the alien graduates of foreign medical schools. If we had the courage or the constitutional authority maybe to take others out, we might do that.

But that is our proposal, plus some studies on nursing and other health professions.

So I think unless I have missed something of substance in the package, that is about as much legislating

as we are likely to do.

I am very interested in what is happening over on Part B. While we are all focused on Part A, seeing all the wonderful things that hospitals are able to accomplish, I want to see what is going on over in Part B, where all this stuff is now starting to show up, and some of it is right in the hospital. Cataract surgery I will mention specifically because that is one I am going after.

But hospitals are able to make a lot of money today. But if there is a hospital in Long Beach, California, that is going to build a $10 million cataract surgery center, thinking the law is going to be changed, my message to the folks in Long Beach is, "Forget it," because it won't be long -- it won't this year, but maybe this year we will legislate for a year or so from now -- that we will make one payment for cataract surgery, period, to the doctor, and he can buy it in a hospital or he can buy it in an ambulatory setting or somewhere else. And it's going to be a whale of a lot smaller than the $3000-4000 figures I have seen assigned for physician and hospital currently.

So some of that, in that area, we will be looking for opportunities to save the reimbursement system for the realities of the marketplace -- always being careful not to penalize people for innovation. We are not going to take advantage of ophthalmic surgery that has found a cheaper way

to do it by cutting them. They are going to make money, but the folks who have been making too much money are going to make less. So we don't want to penalize that innovation.

QUESTION: You don't see any amendments [inaudible] set-aside?

SENATOR DURENBERGER: Well, we don't know. In fact, when I just put a letter together with Heinz and Chafee to go out and sell everybody on supporting the action that we took last week because we don't know whether Kennedy or somebody else on the Democratic side will come with an amendment. There are 12 hours left on the bill, approximately, 12-1/2 hours, something like that, and I would say anything could happen. But I suspect it may not.

But I think the wind is sort of out of everybody's sails. Everybody wants to get a big black into the budget, and I think we will have something in the neighborhood of $250-300 million spending reducer by Thursday afternoon.

Yes?

QUESTION: [Inaudible] IBBs?

SENATOR DURENBERGER: IBBs?

QUESTION: Yes.

SENATOR DURENBERGER: Were you in Miami when I spoke on that subject?

QUESTION: No.

SENATOR DURENBERGER: Oh. Somebody who was there told you that I was against all tax-exempt bond financing?

No, what I said about IBBs, IRBs, and mortgage revenue bonds is that their data is limited, that the objective would be to get back to something like the old general obligation bond, where the municipality or the State -- in other words, government -- had a three percent or a two percent or something advantage in the marketplace for what were truly public purposes. That advantage is down to about less than a half a percent today because we are building Burger Kings and Lord knows what else with tax-exempt bond financing.

So I would suspect that the first part of the process will be to redefine public purpose to get rid of private-placement bonds. In that we need to struggle, I think, in the near term to identify this set of health-related or hospital-related services as public purpose. Now, don't stretch it too far. Not every doctor's office, or maybe no doctor's office, are going to fall. I haven't thought it out. Somebody else will figure that out.

But the struggle will be to get the hospital in as a public purpose, and without distinction between for-profit, profit, public, you know, all this sort of thing, and we're going to have a tax break for everybody [inaudible]. So that will be the main struggle.

If the hospital industry loses out in that struggle, then they're back in the marketplace someplace where ACRS is fighting against the charitable contribution and/or the public support, and then when ACRS goes, as the President steps off the plane from Europe, then we've got a whole other ballgame.

But I have also said, you know where I stand, my State uses IBBs, IRBs, and MRBs better than any other State in the country; is more creative. So I will be the last member of the Finance Committee to vote for the elimination of them.

[Laughter.]

SENATOR DURENBERGER: It's true.

[Laughter.]

SENATOR DURENBERGER: Yes?

QUESTION: You spent most of your time talking about tax [inaudible]. Number one, what proposal do you favor to deal with this? And number two, what do you think will happen [inaudible]?

SENATOR DURENBERGER: Okay. Thank you.

The question is about tax reform, tax spending, what do I favor and what do I think will happen.

My preference would be for us to redesign a national tax system. Rather than trying to reform the income tax, design a national tax system, like you were able

to start from scratch.

Now, that's sort of crazy, I guess, but I think most Americans would agree they would rather start there than just tinker with what we've got. And I think the answer will be that we will tinker with what we have. That means we will get such things as minimum taxes, surcharges of one kind or another, you know, anything we can do to sort of get everybody into the income tax paying net.

What I would favor, of course, is a shift on the national level from a total dependence on payroll and income to a codependence on consumption taxes. And everything -- nobody can make a good argument against the fact that we ought to be taxing consumption in this country.

I tried that on 120 European business people this morning, and everybody, every one of them agreed. They said, "You're giving us a free ride, you know. You put all of your social insurance system in America on your products so that we can come in here and, you know, sell it."

So obviously what I am arguing for is if the regressive taxes in America, the taxes on work, payroll taxes, ought to be reduced by a shift to a consumption tax in the form of some national sales or value-added or something like that. That would enable us to take Medicare, for example, the Medicare tax, we could wipe that out with a three percent national sales tax, entirely.

That means we could get the old folks to continue to pay with their Medicare. They wouldn't just have their 40 quarters and then they go dump on their kids and their grandchildren. They'd continue, by their purchases, to make little contributions to Medicare, as would all of the drug dealers in America, all of those smart lawyers that are getting paid in cash and checks or whatever.

[Laughter.]

SENATOR DURENBERGER: And we would all -- we would all make a little contribution to the system.

But I think there is an enormous gap between $735 billion in revenue -- and that is optimistic -- and $950 billion in spending. That is a large thing to close.

And I agree with the President's theory that we should not raise rates and create, you know, a whole new revenue flow, but we have got to broaden the base of the income tax, and you can't broaden the base of the income tax unless you can get part of the liabilities for tax payments off of income and onto something else.

Is there a last question?

QUESTION: [Inaudible] transition to [inaudible]?

SENATOR DURENBERGER: What is the likelihood of a delay in the transition to a national average on the Medicare DRG rates?

I suspect that it is possible that we will have

to think -- and I am not doing it yet, and I don't know anybody on our side who is -- but we might have to, in a compromise situation, say with the House or something like that, we might have to think about two years at 75-25 or something like that.

But next year we've got to get to 75-25, and I know there will be an effort from California and other places to freeze it at 50-50. But if we compromise on that, then the whole system, they'll just let us sit there forever at 50-50. So we've got to get to 75-25.

Now, maybe we should [inaudible] 75-25 for a couple of years, I'm not sure, but then we have to get to a national average of some kind. And I know the American Hospital Association and others are going to try to urge us to think creatively about what we mean by national averaging, because I can hear it coming already.

But it's worked so far, and I think it will continue to work. Probably it's rewarding some people it shouldn't be rewarding, but I don't think a couple of years out it's going to penalize anybody. People who have penalized folks are us here in Washington. It isn't national averaging that's going to penalize them, it's going to be the politicians who, having promised a formula with an index, will take away the index or eventually destroy the formula for budget reasons.

There was one last question over here.

QUESTION: [Inaudible] what do you see as the legitimate role of Federal and State governments with respect to indigent care?

SENATOR DURENBERGER: What do I see as the legitimate role of Federal and State Government for indigent care as everything gets more competitive?

Well, the first part of that, the first step in that process is to acknowledge a national responsibility. And believe it or not, in 4-1/2 years, we haven't -- I don't think we've heard that yet here in this administration.

But we have a responsibility to finance the access of the indigent in America to some basic set of services. I do not recall having heard that officially any place from Republicans in this town.

I think you have to start and just have to say we're willing. I think the President defined that in his version of the New Federalism. When he did his swap, the sorting-out thing, he implied that responsibility. But he needs to tell some of his friends in the Congress that that is what -- and in the OMB -- that that is what he believes in.

So if we start there, then we can think somewhat creatively about a different federal role. Should our role be cash only or in-kind? Start there. And if it's cash,

you know, through what medium do we provide the money? Should it be in a voucher, or should it be something else?

I favor making the Medicare program the basic foundation for acute and sub-acute care for the elderly and the disabled in this country. In other words, the poor elderly should be in Medicare, not povertized and sent into a State medical assistance program where they get warehoused in a nursing home. They don't have to.

But that's an important decision, if you want to say that Medicare is the program. But it's important to say that because if we ever get consistent with regard to our programs for the elderly and the disabled, then I think the private insurance market will come in and say, "Hey, there are some of these things that we can sell to people. Some of it is shelter stuff; some of this other stuff we can sell people some form of an insurance program to go with your basic health acute and sub-acute health care package." And people can have their elderly years or disabled years packaged in that fashion, with the services all being delivered in the private sector in communities across this country.

Then that leaves us with the working poor or the poor who have some access to the work system, and I think if we once make that decision I suspect State and local government could come up with more creative ways to finance

access to housing and education and lots of other things, and they should then tell us what they want our cash role to be.

Where I stand, I stand in favor of consumer choice in every public service area. I favor education vouchers for everybody. Rather than putting money into educational institutions, I would put it into the consumer. And I would then help States in certain areas with regard to special education and so forth, as a national responsibility.

At the higher education level I would make a commitment to a guaranteed student loan program, and I would say everybody can get into that program, everybody, and you pay it back when you go to work, that one percent of your paycheck or two percent of your paycheck goes back to repay your student loan.

And that's all it has to be; you don't have to Mickey-Mouse it around with five or six different kinds of college programs and income testing and sending the parents to take these six-page interrogatories, you know, to get their kids into school and all that.

[Laughter.]

SENATOR DURENBERGER: Run a welfare program at the college level, that's what we're doing. But we let a lot of folks go out and borrow 20 percent of their adjusted

gross income, then contribute that to the University of Virginia or the University of Minnesota. And they get, if they're in the 50 percent bracket, they make half their money on the interest payment, they make half their money on the contribution, they get a building named after them at UVA for free, at your expense.

And I am not knocking that, I mean I am all for it. Foundations and philanthropy and all that sort of thing. But the reality is that is money just going to the college. That isn't going to be spent half as well as the same amount of money going to a kid in search of an education.

Those of us who have got kids that have been looking at college applications know you can't tell one college in this country from the other, except the girls look different.

[Laughter.]

SENATOR DURENBERGER: I've got nothing but boys in my family.

[Laughter.]

SENATOR DURENBERGER: And they have different numbers of volumes in their libraries, things like that. There isn't real competition at the higher education level. But [inaudible] same thing is true in housing and other public services.

So that's a long answer to a very good question.

I will end by saying that in the short term the poor in America will suffer more than anybody else from the so-called recovery. And I don't know what any of us can do about it. It hurts a lot.

But you would think, in a place like Detroit, they would understand that. Southeastern Michigan had $86 million last year in hospital bad debt, $22 million in free care, and $12 million in [inaudible] obligation. But the fat cats in the United Auto Workers are still raking down the tax subsidy for me in the neighborhood of $1500, $1600, $1700, $1800 per person, per health plan. And they don't understand the connection between the two.

Okay. Thank you very much.

[Applause.]

[Whereupon, the presentation was concluded.]

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VOICE: We are indeed fortunate to have with us today as our luncheon speaker, Senator Dave Durenberger from Minnesota. Those of you who ran our meeting in February here in Washington know that Senator Durenberger was scheduled to address a similar luncheon and unfortunately the weather did not cooperate on that day and he got snowed in, so we wanted to give him an opportunity to come back and to meet our members, and for you to have an opportunity to express your views to him.

Dave Durenberger, and I am going to quote here from the Congressional Quarterly which those of you who are not familiar with Washington is sort of the most objective non-biased observer reporter of what goes on in Congress today, and here are a few comments of what they have to say about Senator Durenberger, which I think probably more accurately reflect the way that he is viewed by the public at large and many of his colleagues than anything that I could make up. Quoting Congressional Quarterly, they refer to Senator Durenberger as "good humor, but he has become one of the most informed and most impressive senators on a wide variety of issues. In nuts and bolts drafting of legislation Durenberger excels. Serving on three standing committees, the 96th, 97th and 98th Congress, Environment,

Finance and Government Affairs, he was an important player on each committee."

Well, that's a little bit out of date because now he has taken over responsibility on a fourth important committee, and that is as chairman of the Select Committee on Intelligence and a position quite frankly inherited at a very difficult time when the intelligence community was under a great deal of attack both here and abroad, and he has done a tremendous job in trying to restore some proper balance and perspective to the congressional oversight of our intelligence efforts. But the CIA and intelligence is not what we are here to talk about today. We are here to talk about his work on the Senate Finance Committee and more importantly the real estate issues as they relate to tax reform.

Senator Durenberger has always been a very key player on real estate issues in the Senate Finance Committee. A few years ago, right after I first joined the National Multi-Housing Council we became involved in an issue on tax exempt bonds. It sounds like this year. It was not this year. It was three years ago. One of the first meetings I went to was a meeting hosted by Senator Durenberger and his staff to coordinate industry efforts on how we were going to find efforts to do away with tax exempt bonds or put limitations on tax exempt bonds back over

almost four years ago now. Thanks to Senator Durenberger's efforts we were able to fight off that effort. We fought another effort on tax exempt bonds about a year and a half later, and we are going to be fighting another one this time around.

Last year we got into an issue on imputed interest and original issue discount. And once again, it was the leadership of Senator Dave Durenberger on the Senate Finance Committee who shepharded through amendments supported by the real estate industry to modify the really onerous provisions relating to original issue discount and imputed interest that were, we think, inadvertently and mistakingly put into the '83 Act.

So, Senator Durenberger has a history of concern and interest with the real estate industry. We've worked with him on a wide variety of issues. We've not always agreed on every issue, but we always found both he and his staff willing to meet with us, willing to intelligently discuss our issues. If we were right and we made the points, Senator Durenberger has been always the first to be willing to take our cause not only to the Senate Finance Committee, but to the Senate floor.

Here at lunch just a few minutes ago we were talking about some of the frustrations that he and we have shared with another senator from Ohio, whose name we will

not mention, but it's not John Glenn, who has been stifling some of our efforts to try to get the OID imputed interest bill off the Senate floor. If we had a few more David Durenberger's in the United States Senate we would not have perhaps a lot of the problems that we have with the tax bill that we have today.

At this time I want to give to you Senator David Durenberger from Minnesota.

(Applause.)

SENATOR DURENBERGER: Thank you very much.

Well, the reason that I am in a hurry and I have to get back to work and you can all sit on your duffs all day is Howard Metzenbaum, a name we weren't going to mention. I haven't sold much since June 30th.

Here is my food diary chart. I just have to write down that I had chicken and rice and whatever it is so that my fitness counselor can tell me how fit I am going to be.

Let's talk for a few minutes about realities and how to deal with realities and then we'll get together again next year and we'll talk about it some more. And maybe in about 1989 the way things are going, we will have a more comfortable -- I have the sort of a feeling that when we get together it won't be a matter of saying, well, Dave prevented this happening to us and Dave is fighting to make

that not happen to us and all that sort of thing. Maybe we can spend an hour together talking about providing shelter to Americans who most of them can't afford it which would be a much more positive way for us to make public policy, and those of you who facilitate.

There is public policy to spend our time together, but the reality is that we haven't since I got here at the end of 1978 I've never been able to sit down and just talk about the national housing policy. I haven't been able to talk to the savings and loan people about it or the bankers or the insurance companies or the bond folks or the developers. All we're talking about is fiscal issues. We're talking about tax and spending issues. We are not talking about housing issues in this country. And I really honestly don't expect -- The advice I was given was come here, give them the hard news, all that sort of stuff. Don't just stand up there and tell them you're for everything they're for. You took care of that by saying that sometimes we agree with each other and sometimes we don't, and that's the reality.

But the practical side of it is that you're all in the shelter business, and I'm supposed to be in the shelter business to some degree. I am afraid that it will be three or four years in this country before any of us can really sit down and find out how best to provide what kind

of shelter to Americans. We are still living in the -- What was it, somebody leaned over to me in the Finance Committee this morning and said, do you know that Henry Kaufmann's prediction this quarter is the same as it has been for the last eight quarters? We are going to have an uptake in interest rates again. I said, my God, how can they pay anybody $850,000 a year to keep saying the same thing over and over. The reality is that he used to be predicted in the days of sort of the expectation as to economics and sort of the first months of monetary economics in the late '70s. You could be predicted, but Henry turned out to be a very famous person. Lots of you people pay him lots of money to be predicted. But his predictions have been the same apparently for the last substantial period of time, and sometimes he turns out to be right and sometimes he turns out to be wrong. He is just like everybody else in this country who doesn't know what tomorrow will bring. That is the reality.

I don't want to get up here and pretend today that I know what is going to happen here tomorrow because I haven't the foggiest idea.

Also in the hearing this morning in the Finance Committee, we had a hearing in the subcommittee on the debt ceiling, whether to raise that to $2 trillion on its way to $3 trillion. And Pat Moynihan was pressuring enough to ask

the Assistant Secretary of Treasury who was there, "Where did I hear," Pat said, "that interest on the debt service this year is approximately equivalent to half of our personal income tax collection?" And the guy looked at his figures and said, "Actually, it is a little better than half. The debt service is $175 billion and personal income tax collection this year is expected to be $331 billion. John Chafey allowed it how he had never thought about it that way before. I only thought about it because I'm the new chairman or I'm the chairman of the new organization called Americans for Generational Equity, whose job it will be to make Americans care about the fact that mine will be the first generation to leave with children worse off than my parents left me.

So, that's why I think about this thing. $175 billion a year, half of the personal income tax in this country going just to pay debt is a hell of a lot bigger problem than fairness, simplicity and growth in a tax system.

I made a little remark about why is it that nobody else around this place seems to talk about that sort of thing? Why does it come as such a surprise to anybody when you could just watch this damn thing building up month after month, quarter after quarter, year after year, and people in the Administration just respond to it by saying,

yes, but as a percentage of GMP it ain't so bad. Well, baloney. You see the impact that has on a whole lot of things, and it is a staggering kind of an impact.

So, those are just a couple of things that I observed this morning that were going on in my life as I prepared to try to come in here and be tough and optimistic and all that sort of thing, and give you all some advice on how to approach your congressional relations in the remaining months of this year and on into the future.

I think the best thing that I can say to you is that you ought to do -- on taxes for example, and maybe I am being general -- you ought to do what the Senate Finance Committee and maybe the Senate as a whole is going to do vis-a-vis the President's recommendation on tax reform. We are going to just sit back and watch.

Most of us can't believe that 33 politicians, no matter how well-intentioned they may be, can rewrite the income tax code in this country and come up with a top rate of thirty-five percent, twenty-five percent, fifteen percent, and wipe out the taxes on the poor in America, that they can accomplish that. We just don't believe that they can do it. Now, more power to them. If they want to try and they want to see what they can come up with, let them go ahead and do it. So, maybe for the first time since I have been here, the House will go first on a tax bill. That's an

innovation.

I always thought when I got here that that's the way it was supposed to work. Ways and Means goes first and Finance comes afterwards. But at least since we've been in charge, it hasn't worked that way. The House has not moved tax bill, so Bob Dole has. I have always been in the position of leading with what we call from time to time, tax reform. I think maybe that's because it's been our President, and he has been interested in tax reform. Maybe that's another reason why we did the leading.

But this year our President and the Democrats are in synch for the first time. So, he's no longer our President or our problem as far as taxes are concerned, so we are back to the way it always has been or at least mostly has been over the last fifty years in this country, where the Democrats will write or rewrite the tax code beginning with Ronald Reagan, secondly Raustenkowski and then on and on. I say, more power to them. If they can figure out a way to accomplish these various ends, if they could get more fairness in the code, simplify the code, bring the rates down to 35 percent maximum on individuals and some lesser amount than 46 percent on the corporate income tax, if they can accomplish that and achieve real estate revenue neutrality, maybe it can be done. At least, I have the luxury of watching that process and I have the disadvantage

of having to come to meetings like this from time to time and try to explain something about tax reform.

Now, what I have found since Treasury 1 came up a year ago, or maybe even before that, thinking loud about taxes -- is that it is time that we did some national -- reform the national tax in this country. But, I also find as I make my remarks about taxes at meetings like this, that the President sense of what needs to be reformed and the people's sense of what ought to be reformed are two slightly different things.

For example, when Jim Baker came down to meet the Finance Committee, to explain Treasury 2 or Reagan 1 for the first time when it was just Republicans in the room, I said, "Jim, are we going to have kind of a guiding set of principles, against which we can measure your recommendations and other people's recommendations?" He said, "Yes." I said, "What are they?" And he said revenue neutrality, operate at 35 percent, fairness, growth and simplicity and that sort of thing. I said, yeah, but those are kind of political or public administration principles. Those are not tax principles. Those have everything to do with politics and nothing to do with my incentive for working and supporting my government at the same time out of my earnings.

And he said, what do you have in mind? And I

said, well, something like consumption versus savings or consumption versus capital investment or something like that. I can measure various of these proposals. And he said, no. Naturally, we are on a trend away from consumption -- well, he didn't even say that. He said, "Well, you know, we favor growth." I said, "I know you favor growth, and so does Jack Kemp and R. Laffer, but what does it mean when you come to make a certain decision?

Take the interest deduction as an example. The whole issue of the cost of capital is reflected in income tax policy vis-a-vis debt financing, has a lot to do with consumption and interest or consumption, savings and investment. And we all need to understand more about that so that we can get everybody on the same playing field. So, whether we're measuring housing or steel mills or automobiles or whatever commodity it is that we are measuring in our society, we have an agreed upon standard of consumption, investment or savings against which to measure.

Well, the answer is that there is no such set of principles guiding income tax reform. But those are the kinds of things that I think you people would be much more comfortable dealing with if you felt you were deaing with national tax reform. When I say that this country ought to remove its incentives for consumption, I find a lot of heads go up and down and agree with me that for thirty years my

generation has been the ultimate beneficiary of my parent's generation who taught me how to consume, and built the whole political structure that lived for today and said the hell with tomorrow. I mean, my parents had me in 1934 in the middle of the Depression when I was the only thing that they could afford to have. And there are a lot of me's -- there are a few of me's in this room today, most of you are younger than I am -- but the reality is that my generation was the first after our parents came to political power to benefit from the notion that we would avoid depressions by being able to have without paying for it.

And so from the '50s to the '60s to the '70s, I was taught to believe that it is better to be sick than to stay healthy, because all of my sick care was free. Housing is a freebie, it does not cost you anything. I have bought more $500 homes than I could imagine, and the last one I sold for $250,000 when I got elected, but it only cost me $500. All the rest of it was paid for by inflation and the tax system, and largely by inflation. Largely by the notion that we could all have without paying for it.

You know, whether it's farming, housing, health, you name it, you can't name one public service or public need in my generation that benefited from that hasn't been guaranteed to me for naught. It wasn't going to cost me a thing. So, that's what my generation was produced. The tax

code says, you know, use the interest deduction, use the employer purchased health benefits. Use this system in some way to have and it won't cost you anything. We are slowly now coming out of that period of time without even wanting to talk about it, because no politician wants to say to anybody, you know, you can't have. But that isn't what I think I am trying to say to my generation. I am just trying to say to my generation that I don't have to do without, and I don't have to require my parents to do without, in order to guarantee that my children will have.

But doggone it, I don't have to lecture this group about what we, my generation, has done to the cost of shelter. I shouldn't -- I guess I don't have to lecture you all on that. I mean, in our efforts to make housing affordable for everybody, we have made it affordable for about ten percent of the population without some kind of "subsidy" wrapped around it. And it is driving us crazy, it is really driving us crazy.

Now, maybe some of the solutions can be like what we did in farming. In farming all we did was we snipped off the income stream at one end, and by doing that drove down the price of the acid value, wiped out the net worth and all of the inflationary equity for a lot of farmers, and we have driven down the price of going into farming down to about 40 percent of what it was five or six years ago. Maybe there

is a way to do that in housing, but I don't know what that is. Maybe all you guys who are in at $40 a square foot, maybe we can figure out some way to drive your investment down to $20 a square foot. Then say, that's what it is. Now, you all have access to housing. Well, I think that is sort of ridiculous. It's not ridiculous to suggeest it, but it is important that we all understand that that's what we're doing to farmers and then you can blame their bankers and you can blame the farmers ell you want, the reality is that in the '70s we took this excess of demand for their product and the easy availability of financing, and we took $200 an acre farm land up to $3,000 an acre, and now we are taking it back down. We are leaving a generation of farmers without farms.

Now, we could conceivably come up with something similar in housing. In case you think we wouldn't do it, the reality is that we don't know what we're doing to the farmers. I just happen to come from a farming state, so I understand what I would have gone through. But we could unconsciously do the same thing to housing. And the notion that plywood or 2x4's or carpenters can demand X dollars from the market place is an artificial notion. I mean, doctors used to think that they could get an automatic $500,000 a year just by adding one more year of graduate medical education and going into some internal medicine

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specialty. They're back down to working for somebody else for $35,000 a year. And it is happening to meatpackers and it is happening to air traffic controllers and it is happening to airline pilots and it is happening to a whole bunch of various industries.

So, the notion that the average cost of your average three-bedroom home or whatever it is in America has to be $86,000. Nobody wrote that in stone any place. I mean it could end up being $50,000 a year. It is not without the realm of possibility. Now, nobody could design how you go from here to there, because these sort of things happen from accident. But the sign is out there in the economy today, in the whole uncertainty of the economy, and the way in which the size of depth in driving the public decision making process, this could happen in this industry.

So, I asked the question whether or not you all are prepared for this sort of thing happening. Again, I don't know how to ask you to prepare for it. But I know that at $175 billion a year in public debt service, and you have to about to quadruple that to get the total in this country today. I guess our total private and public debt is now $7.1 trillion. It was at the end of '84. It is growing at the rate of $1 trillion a year. I just want to say to you, the bubble is going to burst and someplace it is going to explode.

I can make these young people make it explode and I am going to do that. If I could start a revolution in America for people under 35 years of age that said, that's the end of having without paying for it, and the end of sending your problems on to another generation. I would start that revolution. But I don't know that I am going to have to start it all by myself. I think it is gradually and slowly coming.

The farmers in my state are about to revolt. The farmer's union is up here right now from various states in the East, and the farmer's union is sort of an advanced guard of revolution and agriculture. But they're here. And we can quote 6.9 percent, 7 percent unemployment until we are blue in e face. And the President can keep doing that and it ain't going to make a bit of difference because we are living in two economies in this country; one that is going bang, bang, bang along like that with a lot of $4.00 an hour jobs and $4.50 an hor jobs and so forth being creative, and another economy that is very, very uncertain. And again, I don't know where all of this is leading to. I don't want to be predictive other than a group like this, which has made such a major commitment to the future of America, one of our greatest public needs, shelter, needs to be concerned about these issues in that larger context.

I know you need to care about imputed interest

and ACRS and the investment tax credit and capital gains treatment and a whole lot of those other things, but let me tell you in three years from now, a lot of that sort of stuff isn't going to make a hell of a lot of difference. And I am so convinced that the deficit, the size of debt, the inequitable distribution of debt in this country, I don't know who to believe any more about where it's going, but Leonard Silk tells me that a large part of the $1 trillion accumulation in '84 went to leverage buy-outs and mergers and acquisitions and a whole lot of other financing like that. It didn't go into shelter and it didn't go into a lot of the other media needs that this society has.

At some point somebody will raise issues about that in some way or another. Today we are excited by the fact that we've turned the corner. Our attitude basically, except for depressing features like this, our attitude is different. I mean, when I got elected in 1978, people were so sick and tired of government that the danger was that they wouldn't even care about it any more. Then one last stab, they threw a bunch of Democrats out and put some Republicans in and said, you know, maybe this will work. And by God, when they threw in Ronald Reagan in 1980, it worked. And our outlook is different and more positive. Our reliance on centralized decision making is over. Our fettish for regulating everything is over. Our willingness

for taking a chance is coming back. All of the good things that we thought we were having to suppress while my generation was getting fat and lazy and benefiting from all of these subsidies and so forth, well, I think we turned the corner on all of those things.

I can find that people come to me now with ideas, how to do this, how to do that better. You know, there is just a lot of positiveness out there that is what is going to save us by the end of this decade and into the 1990's.

I just want all of you to be around at that point in time to help give us the kind of leadership in this particular area. I know you are multi-housing, but I keep talking about shelter, because that's the business you're in. Now, if I had a bunch of teachers in here, I'd be talking about education. If I had a bunch of doctors in here, I'd be talking about health care. But because you're here it is shelter.

I have figured out personally all of those other things. I got the health system turned around, me and a few other folks. We got the whole health system turned around. We got a whole new market oriented consumer choice way of paying for health care in this country. People are not going to get by with smoking, drinking and getting fat and having somebody else pick up the ticket. And by changing the incentives, we are changing the way that doctors work

and hospitals work and the whole system. It will be terrific here in a couple of more years. I don't understand it, what it's going to look like, but I know the elements of choice and competition are working.

And I know that the same thing can happen in education. All I've got to do is stop raising taxes and giving in to school boards. But raise your taxes or do whatever you want and get with the people and let them make choices. I've got that one figured out.

But I haven't got shelter figured out and it is driving me crazy. I have four boys who are 18, 20, 21 and 22 and none of them can afford to buy "their own home", to say nothing of renting from somebody else other than to put 50 percent of their take-home pay after I tax them so that their grandparents can go live in Florida and all the rest of the sordid stuff they have to put up with, 50 percent of their money is going into a roof over their heads today. That is unconscionable. I can't figure out what to do about that. So, I come to you to ask you while you're doing the near-term thing in helping me with the impunitive interest and trying to find the secret of Howard Metzenbaum and helping us to deal with whatever the House is going to do, really think if you will as an organization about this larger issue of where we're going to be at the end of this decade as a nation in terms of providing shelter to America.

I don't think there's a national commission looking into this. I don't think anybody is looking at this. What is our policy in this country? How are we going to get there? What is the role of the private sector and the public sector? What is the financing system going to look like? Are we going to continue to finance debt, are we going to continue to finance builders or are we going to finance consumers with housing? Can we adopt some of these notions that we have in the health care area and we're building in the education area? Can we build those into housing? Can we start subsidizing the acquisition in some way different than what we've been doing before? I don't know. I just don't know. And I'll never figure out the right answer. That's why I leave you with that challenge.

I haven't addressed any of the specifics that you may have gotten into with Berrill and Bob Mitsui and others this morning. I would be pleased to do that.

(END OF TAPE.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

11/18/86

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MODERATOR: Over on my far right is an individual who is a director of four different rural electric organizations, his own rural co-op, Farmers Electric Co-op in Iowa, Central Iowa Power Co-op, the Iowa Statewide. And he is also a director on the NRECA board from the State of Iowa, and he is on the operations committee, which is the group that oversees all of NRECA. And that is Darryl Scott.

[Applause.]

MODERATOR: And next to Darryl Scott is an individual who is president of Cooperative Power Association in Minnesota, and he is also president of Novo's Electric Co-op, his local distribution co-op, and he also is the NRECA Minnesota director, and he serves on the operations committee. Jay York.

[Applause.]

MODERATOR: And of course you all know Bob Bergland. And all I want to say while Bob is here, he just did a beautiful job this morning in stretching our horizons, and we appreciate it very much.

[Applause.]

MODERATOR: I want to go over to our far left. This gentleman is manager of PD Electric Cooperative in Darlington, South Carolina. He is the NRECA South Carolina

director. He is on the central GNT board, I believe, the Statewide board. He is the NRECA director from South Carolina. Also on the operations committee. Robert Williams.

[Applause.]

MODERATOR: And next is the individual who, with Barbara Rouse, developed this conference. You tell me all the good things about it, but if you have any complaints, you see him. And this is Jack Wood, who is the manager of conferences and special projects for NRECA.

[Applause.]

MODERATOR: And next is the gentleman who is manager of the Central Valley Electric Cooperative in Artesia, New Mexico; serves on the New Mexico Statewide board. He is the vice president of NRECA, Don Ethington.

[Applause.]

MODERATOR: I debated about putting this next fellow down where Darryl Scott is, but I didn't want to have all the Minnesotans to my right, so I put him over here. He is a Minnesotan. His father served for years on the NRECA board. He is one of our really fine legislative representatives, Cliff Osey.

[Applause.]

MODERATOR: And to my immediate left is an individual who needs no introduction. You heard him at your

regional meetings recently. He is the president of NRECA. He serves on the Yampa Valley Board on the West Slope of the Rockies. He is a rancher. He is on the Colorado UG&T. And this is Vern Williams, the president of NRECA.

[Applause.]

MODERATOR: What we are going to do is, of course the Senator is going to talk to you, and then after he is finished, we are going to open it up to your questions.

Now, in a room of this size you are obviously going to have to really beam out. But again I hope you will raise a lot of questions because he says he wants to hear from you.

So I am going to call on Bob Bergland.

VOICE: I am supposed to introduce him.

MODERATOR: You're supposed to introduce him?

[Laughter.]

MODERATOR: I've got to introduce him, but he's not here to hear it.

[Laughter.]

VOICE: We'll have to wait [inaudible].

MODERATOR: He stepped out, and I really don't know how to do this, to be honest with you.

[Laughter.]

MODERATOR: Why don't I just introduce Jay York and we'll pretend he is the Senator?

[Laughter.]

MODERATOR: He kind of looks like a Senator, doesn't he?

[Laughter.]

MODERATOR: He's got the flare, he's got the right color shirt. Made for television.

Dave, Senator Durenberger -- here he comes. Here he comes.

Senator, I was about to introduce Jay York. He was going to take your place.

[Laughter.]

MODERATOR: Dave Durenberger is a second-term Republican Senator from Minnesota. He is an unusual Member of the Senate. As a one-time House Member, we used to regard the Senate as "the other body." It was always referred to as "the other body." We always believed that the Senate should be granted the powers to debate but you should never let them appropriate money.

[Laughter.]

MODERATOR: Dave Durenberger is an independent sort of person. He is regarded by his colleagues as one of the extraordinarily bright and creative Members of the Senate. He is known for his fierce independence. He is intellectually independent. He is politically independent as he can be and still get along in that politically

sensitive body. He is a creative sort of person who is willing to run against the grain. He is one of those persons who is strong enough to stand up and say, "This is right. I'm going to do it even if it's not the most politic thing."

The people in Minnesota like Dave Durenberger. I like him as a friend. He is a valuable asset to the United States. Lately he has been deeply involved in matters relating to the Iranian dispute. He serves as the chairman of the Select Committee on Intelligence. He is also a member of the Committee on Environment, Public Works, and Government Affairs.

It is a pleasure and an honor to introduce you to one of the distinguished leaders of our time, the Senator from Minnesota, Mr. Durenberger.

[Applause.]

SENATOR DURENBERGER: Thank you very much, Bob.

You notice, after he was about to introduce Jay York as the Senator from Minnesota, I sat down in the general manager's seat. So you get a new general manager for NRECA.

[Laughter.]

SENATOR DURENBERGER: I'll say Bob Bergland is fiercely independent. He used to be a Democrat, now he's a fierce Independent. But you can't tell by this crowd,

looking at this crowd, where you're coming from these days.

[Laughter.]

SENATOR DURENBERGER: I was asked by Bob here -- this Bob, the cooperator -- to make a few remarks about where we are in America and where we might be headed. Keep it brief. He knows I succeeded Humphrey in the Senate. Keep it brief? he doesn't know what he's talking about.

[Laughter.]

SENATOR DURENBERGER: But I will. I promise I am going to be brief. And then I am going to shut up because this is cooperative education, and some of us at least take that seriously.

Like Bob Bergland, I am not a professional politician. I got it as a job in midlife. I was already 44 years old, I think, when I got elected. The first elected job I ever held. And I plan on it being the last one that I hold and I don't plan on holding it forever. But I'm not going to be easily pushed out. So but anyway --

[Laughter.]

SENATOR DURENBERGER: I have my own view.

[Laughter.]

SENATOR DURENBERGER: That's where things are headed. And I apologize for departing for just a couple of minutes.

But I am chairman of the Senate Intelligence

Committee, and right now we are in the middle of trying to be helpful to the President rather than critical of the President in a situation in which he probably got in a little deeper than he ever thought that he might get into it.

Each time you come to Washington, you have to learn one big word. So the word we're going to learn today, in case you don't know it, is oxymoron. Oxymoron. It has nothing to do with mental health or stupid politicians or anything else.

[Laughter.]

SENATOR DURENBERGER: Oxymoron. An oxymoron means two words which, when used together, are mutually inconsistent. In other words, they just don't make any sense, like "honest politician."

[Laughter.]

SENATOR DURENBERGER: Anyway, let's see what kind of reaction you have to this: I am chairman of something called Senate Intelligence.

[Laughter.]

SENATOR DURENBERGER: How do you like that?

[Laughter.]

SENATOR DURENBERGER: How do you like that for an oxymoron?

[Laughter.]

SENATOR DURENBERGER: And I used to, for two years, be a member of Senate Ethics.

[Laughter.]

SENATOR DURENBERGER: People laugh at that, too.

[Laughter.]

SENATOR DURENBERGER: That's terrible. My own constituents laugh.

[Laughter.]

SENATOR DURENBERGER: Gene Sullivan, don't laugh. That's not fair.

I am also a cooperator. Nobody from -- there isn't anybody from Minnesota who gets into politics that I know of in Minnesota who hasn't come up in one way or another, at least very few -- maybe there are some of these younger whipper-snappers or whatever -- but there are very few people who have lived in Minnesota from the '30s on who are not cooperators.

We are the heart of the cooperative movement. And I am one of the few people around here that doesn't go around here referring to distribution co-ops or GNTs as REAs. I mean REA is the financing mechanism. We think that's wonderful. We keep the money flowing, you know, and the opportunity flowing.

But I was lucky when I went and got my pinstripe suit, which comes with going to law school, that I was lucky

to go with a law firm in South St. Paul, Minnesota, which used to be the largest livestock market in the world -- I think it no longer is -- but to be going with a law firm which represented the Minnesota Association as well as a number of distribution co-ops, which got United Power Association started and which gave a lot of young people, including me, sort of a start in real life.

So I am not new to the small-p politics of NRECA. I was born in Gene's district up there in Stearns County, where we'd be getting our power from him if this little college campus didn't generate their own power, we'd be borrowing power -- buying power from Gene Sullivan and Stearns County.

So I come here as a cooperator and I come here, believing that there has never been a time in the nation's history when we ought not to find some way to learn from each other, and, hopefully, we are going to prove that during the course of the time that we have together today.

In the last week or two we have all been asked to sort of reflect on the '86 election. And most people have said, "Well, it doesn't mean a lot. It doesn't -- it doesn't have a lot of meaning, so that folks like me who are up in 1988 should just sort of ignore the '86 election, sort of forget about it. It doesn't tell you anything."

But it does. It does help us in even-numbered

years. After we get all the drivel off television and out of our mailboxes and all that sort of thing, it really does help us to sit down and think about why we either voted or didn't vote in this year.

Now, I have come to the conclusion that there are four reasons why people should vote in a society like ours. One is where there is an issue of values. Two is principles. Three is some policies. And four is personalities. Values, principles, policies, and personalities.

Now, one way or another, most of us are used to thinking about, "I am going in there because there is some value that I want to establish, a sort of a societal value. Or there is a principle at play here."

Now, a lot of people have been going in the last ten years because of a value called living within your means. That to me is a value. My parents, who had me in 1934, when I was all they could afford to have, taught me I ought to live within my means. Then after they came to political power, they took it away from me.

[Laughter.]

SENATOR DURENBERGER: You know. I got the first free house, nothing down, forever to pay, you know, 30 years, 4.5 percent interest, you know.

But they still believe in it. Live within your

means.

There is a corollary value to living within your means, which is: take responsibility for your actions. They go together. Take responsibility. If I got free housing or I get a free farm because all it takes is a trip to the bank, and I ain't got no responsibility that goes along with it, I've got a problem.

Now, we can go to the polls like they did in the mid to late '70s, I think, and vote values. We've got to learn to live within the means; let's start with the government. Jimmy Carter said, "I can balance the federal budget because I am from Georgia."

Anybody here from Georgia?

[No response.]

SENATOR DURENBERGER: Huh?

[Laughter.]

SENATOR DURENBERGER: Well, anyway --

[Laughter.]

VOICE: [Inaudible.]

SENATOR DURENBERGER: He didn't do it. He didn't do it. So we elected a movie actor, a 70-year-old movie actor, in 1970.

[Laughter.]

SENATOR DURENBERGER: And it's three times as bad as it was when Carter was there.

[Laughter.]

SENATOR DURENBERGER: So we haven't voted those values recently.

Now, how about principles? I think one possible principle could be: what do we expect of the Federal Government or the State Government or local government? I mean, I believe in the principle that the best government is the government closest to home. Now, Ronald Reagan really believes in that. He is getting the Federal Government out of a whole bunch of lines of business.

Now, you could go and you could debate that principle across the country. The best government is that closest to home. We ought to get the Federal Government out of our pocketbook, off our backs and out of our pocketbooks. Those are kind of principles. You could think of others. You could think of other principles, too.

But we haven't in the recent, the last two elections, we haven't debated a lot of principles.

There are policies. Now, policies we got a lot of because from values flow principles flow government and policies. We got a lot of policies. Right now we've got an agriculture policy that is being debated all over the place. We could debate that from now until 5:00 this afternoon; we wouldn't resolve a thing but we could have a heil of a good debate in this room, a heck of a good debate.

Really, we could debate trade policy. We could debate economic policy. We could say, "Doesn't it occur to anybody that America is becoming a giant bazaar?" We are a great place for everybody all over the world to bring their stuff to sell. Now, is that good economic policy? Is it or isn't it?

How do you save steel in America, steel manufacturing process? How do you save automobiles? How do you save manufacturing? How do you save mining? How do you save agriculture? See? So you could go and you could debate a policy.

Intergovernmental policy, I am an expert on that. Health policy, I am an expert on that. That's why I am here today, by courtesy of my publisher. I just -- my latest book is called Prescription for Change. And it's got principles in it and policies. And it talks about how you can, in government, do better for less.

So -- but did we do that in 1986? Did we debate policies? No. Did we do it inn '84? No. What did we do? Personalities and feelings. Right? 1984, the campaign was all about do you feel better today than you did yesterday and do you think you're going to feel better tomorrow?

And all the folks that had good feelings went to the polls and they voted for Ronald Reagan -- except in Minnesota.

[Laughter.]

SENATOR DURENBERGER: Except in Minnesota. We didn't do it in Minnesota. But we still took the feelings to the polls. And we voted those feelings.

1986, same thing happened. The difference: All the folks with the good feelings didn't have anybody to vote for, so they stayed home and the folks that weren't feeling so good went to the polls.

But did they give me any instruction on what to do? It was I told that the deficit is the biggest problem facing this country, that living within our means is a value that I have to get back to and some specific instructions on how to do it? Of course not.

Did they, did I, did you -- in any sense of how we ought to change our values, our principles, or our policies in this country in order so that you don't have to go and just vote your feelings or you don't use the polls and politicians just because you feel bad or feel good, that you use it the way you're supposed to use it, and that is: to better the lot of this society in the larger sense.

So we have no instructions. So now you've come to Washington, you do cooperative education. Your headquarters is located here; I suppose that's why you come to Washington. Otherwise you might as well be in Wichita or better off in the Twin Cities or in Worthington or someplace

like that.

[Laughter.]

SENATOR DURENBERGER: No point to come here. We don't have any marching orders. We don't have any instructions. We haven't been able to get them where you get your instructions, which is from the constituents in even-numbered years.

Now, you know, I got my own set of instructions because I spend a lot of time at home. I got my own sense of values, my own sense of principles and so forth. But the odds work against my being myself in this system because what you and I have done over the last 15-20 years is turn most politicians into entrepreneurs.

Rather than being part of a larger collective, corporate, if you will, endeavor where everybody pulls together -- the Democrats all pull together and they do certain things, and the Republicans all pull together and they do certain things -- every one of us now is encouraged to be our own entrepreneur: Dave Durenberger is an expert in health policy, he is also an expert in intergovernmental relations, and so forth.

But does he have to pull in the saddle, you know, when you need that 50th vote? Does he really have to get in there? Or does he take care of himself?

We have created too many entrepreneurs in this

society and not enough of us who operate collectively.

Now, in the last six years, one of the best things that ever happened to this country was a Republican Senate. Why? Because time after time we set an agenda that said the biggest problem facing this country is its failure to live within its means.

The only way you're ever going to live within your means is by balancing the federal budget and being an example to everybody else as to how you ought to do it. And so we took all the tough votes to do that. On top of that, we've done a lot of other things.

Now we're gone: we're back in the minority. We can be individual entrepreneurs and blame the Democrats for all the problems. And where are you left?

What did we vote in the '86 election? I think I have already said, in large part, for the people that had -- well, I'll tell you what it was. I think I know what it was in the Seventh and the Second Districts of Minnesota, where we almost lost two Republican congressmen. I'll tell you what it was: It is people for whom just reducing inflation from out of control to zero, just reducing interest rates from 22 percent to 7.5 Reducing unemployment from 11 to 7, turning the country around, creating more optimism than we nave ever had before wasn't enough.

Are they the greedy? No. No. They're the

people who have paid the price of uninflating the economy. They are the people in this room who are the deflators.

I told you I bought my first home for nothing down. I was a vet, so I get -- I got a free house just like I got a free education, and I got forever to pay. From 1960 to today, I took the price of housing in America from $5000 on the average, to $86,000. Now my kids have to come home and live with me.

But my house is still worth, out in McLean, Virginia, $350,000. But I'll bet you in this room I am going to find somebody who thought they had a $60,000 home in some small town in America, and today it's 10 or 12 or 15 or maybe $20,000. Man, they're all over my State. They're all over my State.

Now, that's in agriculture, or you can come to the mines up in north, northeastern Minnesota. Go to Silver Bay, Minnesota, created 25 years ago. There was nothing there. They created a city, Reserve Mining Company. I was there two weeks ago, and I looked at 400 people my age who will never work again. They closed down the plant, bankrupted the mining company.

What do you think their homes are worth? I asked. $7000. $7000. So now I go around and I encourage people like you to go to Silver Bay and buy a great summer home. Maybe you have a little place in Florida. Maybe

you're getting ready to retire from wherever you are in Colorado or someplace like that. Come to Lake Superior. You can't find a lake like that in Colorado. It's beautiful.

VOICE: [Inaudible.]

SENATOR DURENBERGER: Right on the shores of beautiful Lake Superior, get yourself a very inexpensive summer home. But look at it from their side of it. For our generation, where has our savings been? They've been in the bank? No. They've been in the savings account? No. Have they been in an IRA? Well, recently, some people. They're in our homes. I've got a $400,000 savings account, and the folks in Silver Bay have got a $7000.

But we all started out the same place. We bought a $5000 home 25 years ago. And so the same thing has happened in agriculture in America that's happened in mining and other places. People go around beating up on the bankers and all that sort of thing. Bull. It's us. We took $200-250 an acre farmland down in Nobles County and we took it up to $3500 an acre -- on the same theory. And now it's down to $500. Instant millionaires? That's not the way to look at it. Those are families.

So what are they worth now? They're worth the difference between what they owe on the property and what it's worth.

So -- but I can do this for you as we've done it in the Intergovernmental Relations Subcommittee in a little booklet that Bob and -- that the Bobs were smart enough to buy and some of you may have seen, called "Governing the Heartland," to show you there is a very substantial difference between rural America and urban America today. And it used to be just the quality of life. But today it's economics. And if we don't wake up to that fact, we as a society are all in trouble.

You want to talk about the poor? Don't come to downtown New York or Washington, D.C. There are plenty of examples here. A lot of homeless in Washington, D.C. You can walk around at night and you can find people on the grates. But you don't have to come here to find them. You've got them all over worldwide.

Our capacity to care for them, though, is running out. When property values go like that, when your income goes like that, who is going to raise the money to teach your kids? Who is going to raise the money to do social services?

Who is going to provide for the mental health center so that the farmer who sits out there all by himself thinking that it's all his fault -- and it isn't, it isn't, it's a societal problem -- who's going to counsel him before he blows his brains out? Who? The priests, the ministers?

Yes, they're trying.

But it's a larger problem, and it's larger than farm crisis. We could dump -- Republicans should dump on the boycott, see, blame Bergland and Carter and all that sort of thing. It's a much larger problem than that. Much larger.

In part, it's deregulation and decentralization and things like that, you know. And we are now in a big hurry to pay for what we get and buy only what we really need. So we deregulate transportation, we deregulate the phone company, we deregulate everything. And what happens when you deregulate it? You try to put the cost on the consumers.

Okay. That's something the cooperators understand since 1935. We have discovered that if you put the total cost of a service on all consumers, not all consumers are going to get electric power or telephone service or transportation or anything else.

[Inaudible] in power we did it a little bit different. No more of a direct subsidy where you can see it in the cost of borrowing money. There are different ways in which we have done that, but now in our hurry to efficiency, to have everybody pay the actual cost of all the services, we run into the problem of the law of large numbers. You all know what that means. In the cities, when you

deregulate, the prices go down; in the country the prices go up. Right? That's the way it is.

So what we are faced with in rural America is that our worth is down, our income is down, and our costs are going up -- all for the good of the larger United States economy. And I think it is a good. I think that getting inflation out of our lives is good. I think living within our means is imperative. I think taking responsibility for our actions is long overdue.

But what we in Washington don't understand unless you beat us up with it is that not everybody in this transition is treated alike. This whole theory does not treat everybody alike, so we have to think of different ways to do it.

In governance, we are going to targeted fiscal assistance. General revenue sharing dies. That doesn't bother the folks in the big cities, but it really hurts you if you're a township or a small village.

Forty-four percent in this study we did of the ten -- from Arkansas to the Colorado, I think, up through Minnesota -- the ten States we took, when you cut out general revenue sharing, that means 44 percent of federal aid to rural communities is gone.

In the cities it's like 18 percent. You know, they hardly miss it. But in small towns too, we have a

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substitute for that, called targeted fiscal assistance. It uses half as much money but puts it in all the places that actually need it. There are ways to deal with each of these problems but -- the deregulation, the downturn in the economy, and so forth -- there are ways to deal with them.

But until you understand what's at stake -- and I am going to stop here -- that it isn't the fault of the farmers, it's not the fault of the bankers, it's not the fault of the realtors, you know, it ain't no one person's responsibility. It's a whole generation. My parents had me in '34, I told you, when I was all they could afford to have. And the parents of that generation swore that when they came to political power, I was never going to hurt the way they did, and they created "having without paying for it" for my generation: free health care, free practically everything else.

Now I can smoke myself right up to the verge of death and insist on an artificial heart. I can drink myself right up to the edge of death and insist on a liver transplant. See?

But what has that got to do with responsibility? Absolutely nothing. Individual responsibility and collective responsibility. So we all got into this thing together. It was all very well-intentioned, and now we are searching for the ways to come out of it.

And I can't think of a better time for an organization that began in the Depression, that began with a sense of having but willingness to pay for it but just let us have a chance to have, which does represent rural America, which does understand the difference between the country and the city, which doesn't insist on being treated equally, never a better opportunity for an organization like this to stand up and be counted in a personal sense and in a political sense, if you will, on behalf of rural America.

And so my purpose in accepting your invitation today, besides the mutual education, was to thank you for picking up a copy of "Governing the Heartland," to thank you for 50 years, now 51 years, I guess, of being the real cooperators in our society, and to challenge you to help people like me get this country not only turned around -- because I think we are already turned around -- get us on the right track and try to do it as soon as possible with as many as possible of us on board.

Thank you very much.

[Applause.]

MODERATOR: Are there questions or comments? Why don't we just have you handle this thing, Senator. And this is a livewire lunch, I'm sure they'll come at you.

SENATCR DURENBERGER: Yes, sir?

QUESTION: My name is -- I guess I can introduce

myself -- my name is Joe Davis. I am a member of the Texas Electric Cooperative of South Louisiana, and I am also [inaudible] parish council. It's the same as [inaudible] in other States [inaudible] country [inaudible] board of directors [inaudible] cooperative and county government [inaudible] rural Louisiana. And everything you say hits [inaudible] you're not very much older than I am and [inaudible] once.

[Laughter.]

QUESTION: But [inaudible] talking about federal revenue sharing, that is something that has really hit us very hard [inaudible] I assume it's [inaudible] go back and again tell my fellow colleagues [inaudible] we'll never see that again.

SENATOR DURENBERGER: Yes. You're right. You're not going to see general revenue sharing again, but you have to see some form of targeted fiscal assistance. The best program we ever had out here was the general revenue sharing program because it took the inflated part of the income tax which was coming in here in droves and sent it back without any mandates to it.

So what has to happen next is that NAACO and the League of Cities and everybody else has to get behind a new version. And I call it targeted fiscal assistance. And it has half as much money, but it targets it on the basis of

community need.

QUESTION: And also, one thing [inaudible] really appreciate -- I should have asked this [inaudible] it appears that [inaudible] Republican [inaudible] I'm sure you [inaudible] but the point is that it would send lights to my house and my small business, my mother and father and my friends in the rural electric. And I appreciate the fact that in your remarks as to where you are and your feelings toward rural electric cooperatives.

Another thing in Louisiana, the government mandated us, we have [inaudible].

[Laughter.]

SENATOR DURENBERGER: Can we call that "big cajun"?

QUESTION: [Inaudible] natural gas we [inaudible] probably [inaudible] the South and half the Midwest [inaudible] electricity [inaudible] natural gas.

Deregulation, I know what you're talking about because the [inaudible] I think it comes out [inaudible]. Being from Louisiana, dealing with people like Kerr-McGee and [inaudible] -- by the way, I'm in transportation, and I own a small trucking company, so I know about those companies. But [inaudible] first big contract [inaudible] Kerr-McGee, finally we have a new [inaudible] renegotiated. They're dealing with Shell Oil, and I think that coal is

about $5 or $6 a ton when it comes out of the mine; by the time it gets to south Louisiana it's about $40. And we still have all kinds of valve shutoffs and natural gas all closed up. We can't use the gas, we use -- over in Wyoming [inaudible] Kentucky and Virginia couldn't be used because of the sulfur content or whatever it was.

SENATOR DURENBERGER: Yes.

QUESTION: We do have our problems in Louisiana. So even when you get back and you get back to working with the Louisiana Senators, they know me personally, help take care of the rural electric co-ops and let's see if we can sell some natural gas and some oil.

[Laughter and applause.]

SENATOR DURENBERGER: All right. Well, the education is working.

[Laughter.]

SENATOR DURENBERGER: I really hadn't thought about that. Having gotten to the Senate in '78, my introduction to energy policy, of course, my reintroduction to energy policy was in the crisis of '79. And boy, are you right on how we screwed up this country at that point in time.

Okay. Who had the next [inaudible]?

QUESTION: Listening to a Minneapolis station and [inaudible] elections [inaudible] a reporter asked what you

thought of the race when [inaudible] cited the fact that we had the two economies, the rural and metropolitan. And you said that you had to treat the rural people better. How do you think we can do that?

SENATOR DURENBERGER: Okay. The question is: If it's true about these two economies, that we have to recognize, we have to treat the rural economies in America better or differently and so forth, how do you do it?

And in each of these cases I start with: First, we've got to agree on the nature of the problem. We have to agree that what little bit I have said here, and I could say more about it, in terms of the difference between rural and urban America are for real. So that's the first thing. Get the folks who run the country to agree on the nature of the problem.

Then secondly we have to make some decisions. I think first what you do is start by undergirding the decisions that have to be made by rural governments, for example. So, recognizing as we have in Minnesota that the tie between State and local financing is very, very important, has to be done in other States.

One of the things that has helped us in southwestern Minnesota and other parts, of course, is that our school aid formula -- some of you I am sure are on school boards -- our school aid formula, in Minnesota, we

have about 75 percent of the elementary and secondary money comes from State sources and 25 percent from the real property tax.

So what we have done is adjusted our school aid formula so that to the degree that the local property tax base goes down, the State fills in the void from State-based income.

Now, the relationship, that is going to help us in rural parts of Minnesota. And so that relationship between your State Government and your rural governments become very, very important.

The second thing that is related to that, of course, is that as we flow federal monies back into the system, we have to do it not any more on some of the old conditions, which were environmental impact statements and a lot of things like that, we have to factor in a different set of needs formulas for rural government. And I have designed that kind of a formula. And it's based on the State's capacity to raise income and the local capacity to raise income. That's the second way to address that problem.

The third way, just to get on with the business of identifying national purposes, this national government has learned through the last 20 years -- I don't know why I look at you --

[Laughter.]

SENATOR DURENBERGER: -- but I always figure like I got here after things started to change or something like that.

[Laughter.]

SENATOR DURENBERGER: We built a government that was all things to all people, and we've got to sort this thing out. And one of the things we can do for poor governments -- because there are poor governments in this country, too. You put Mississippi next to Texas, Texas is doing a heck of a lot of complaining right now because it's in trouble. But Mississippi next to Texas, if you want to raise the same amount of money per capita, you've got to -- your tax rates in Mississippi got to be twice as high as your tax rates in Texas.

We've got a lot of that going on in America that needs to be addressed as well. And one of the things that we can do, whether it's in our welfare programs or whatever, is put in factors of need.

Another thing we need to do in national purposes is sort out where there is a national responsibility for income maintenance or welfare. We have to make that decision. That's another thing you can do.

Then you have to deal with economic issues. You've got to deal with the future of mining and

manufacturing and farming and so forth, and you can take each one of those and debate it till literally the cows come home but we haven't even started the debate, because the theory, I think, in the last six years has been that if we just go to the market and economics the market will take care of turning everything around.

And it may well be the case in some areas. But now we've got my friend down there at the end of the table, he's got a Senator from Iowa who is quite a populist and he's got to deal in agriculture that says, "By God, the thing to do is let the farmers have the opportunity to take land out of production. That will solve the problem."

Well, what problem does that solve? That solves the problem of a past overproduction. But all it does is tell the folks in Argentina and Brazil and a whole bunch of other places what they already told Jimmy Carter -- and I want to say real quick, Bob Bergland was against that boycott; I think you all knew that when you elected him -- but all it does is tell the folks -- and this is from being the chairman of the Intelligence Committee, too, and that's the real intelligence, not the smart --

[Laughter.]

SENATOR DURENBERGER: -- it says something to those people about the fact that they ought to go into more production.

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So, you know, none of these are real easy. But coming to grips with the nature of the problem I think enables us much more readily to come up with some solutions. And I have to end this by saying I would love to stand here and say I have the solution to all of these problems. But I don't.

I don't think there has ever been a better time in the history of this country -- I know you don't want this responsibility -- but you're in charge. You are in charge. And we are going to the market, if you will, in terms of the delivery of services and economics and so forth. But you have to encourage your congressmen and Senators and everybody else to get off of the easy solution and the more money and the "just cut spending" and the "just cut taxes" and get them to deal in the way that we have tried, I think, here today to deal with some of these problems.

Yes?

QUESTION: Senator, I would like to hear from the Senator what he thinks about this Iranian question and how we can possibly get -- be getting back to the [inaudible].

SENATOR DURENBERGER: Yes. The problem then with the Iranian -- there are several problems with the Iranian situation, and one is the expectation that you can do business with religious fundamentalists at this stage is too great an expectation.

So I think the President overreached in his hopes that somehow he could use trading spare parts for a relationship with some people in Iran.

We have to go through another Iranian revolution. I mean Khomeini has got to go. At some point he's going to die unless he gets a bypass or something.

[Laughter.]

SENATOR DURENBERGER: But he's got to go. And we have to deal in a different environment because right now what we tried to do, we tried to deal with some of the folks that are there, and they can't deal today. They can accept our gifts, they can release a hostage, but they can't make any deals today as long as Khomeini is still alive because there is a battle going on behind the scenes as to who is going to succeed him and all that sort of thing.

So just the hard part is we are going to have to put up with a lot more terrorism, a lot more revolution. They are trying to undermine the Saudi government all the time, that sort of thing. We are going to have to put up with a lot more problems from Iran before we get to any solutions. And the President just, I think he made a mistake in the course that he chose.

The other issue that is involved, of course, is whether or not he should report to the eight key Members of the House and the Senate when he does one of these sort of

things. I have long believed that would be helpful to the President because he sits there totally isolated, wondering. I would never, I would never want to be President of the United States. You are totally isolated from reality.

Everybody, if he walked into this room everybody would tell him how great everything was and ask for his autograph, "Oh, Mr. President, that speech you gave the other night was fantastic." There's a lot of you, you'd think now you'd have the nerve to talk to him, but you wouldn't.

[Laughter.]

SENATOR DURENBERGER: You know, just the excitement of being in the same room with particularly somebody like Ronald Reagan, who just exudes compassion and feeling, you know.

QUESTION: [Inaudible.]

[Laughter.]

SENATOR DURENBERGER: Boy, I tell you, this is a great room [inaudible].

[Laughter.]

SENATOR DURENBERGER: So that's the heart of the problem.

[Laughter.]

QUESTION: When he was elected, he was going to balance the budget.

SENATOR DURENBERGER: Yes, that's right.

QUESTION: And he spent more in four years than the first 200 years of the country.

[Laughter.]

SENATOR DURENBERGER: That's right.

You had a question?

QUESTION: I'm from Nevada, east central Nevada. And I am a rancher. Now, we were willing to deal with the PIK program, which really hurt us. But why only imports? I mean there is a balance of trade. I understand we have to balance a certain amount. But then we have all this cattle coming in [inaudible] we have that [inaudible] and we have other things as well.

Isn't there some way [inaudible]?

SENATOR DURENBERGER: You know, you've just put your finger on it -- and Bob can tell you this in spades -- but if there is an industry in the world that is protected, and we get the brunt of it, it's agriculture. I mean, wherever you go around the world, everybody has got a cow and an acre.

And I went back this last summer, took my mother back to Poland, and we went back and we saw the family farm that her father left in 1895. And it's still there, you know, and it's eight acres. And it's about a mile and a quarter long and about 82 feet wide, you know, and it's the

same farm, you know, all those years. And by God, they take care of those farmers in one way or another.

So it is that part of fair trade, if you will, in agriculture is extremely difficult to come by unless you deal in a larger economic context. And I think that is the argument that people like Bob have always made in their advice to a President that you have to put the agriculture economy in a larger, interdependent world economy: "You've got nickel and I've got agriculture, you've got cobalt and I've got agriculture, you've got the need to get into my market."

I mean, look at this, we ought to be selling this bazaar. I mean, we are buying everybody's anything. We've made -- the Japanese standard of living now, I mean, the average, the average income or the average wage of Japanese workers is now at least equivalent with if not higher than the United States. And we've done that for them.

And right behind them are coming the South Koreans and the Taiwanese and everybody else. We are really -- but what are we getting for it?

So I think the argument that I know Bob made when he was there and a lot of others -- maybe this is sort of Midwest stock when they get to Washington -- makes the argument that you need to put agriculture and agriculture trade and economics in a larger context of the

interdependence of this whole world. Everybody has learned their agricultural economics off of us, they've learned about feed and seed and livestock improvement and a whole hell of a lot of other things off of the United States of America. They will always be dependent on us across the world for this.

So, but how do you put that into play? I think that sort of thing is on the way. I mean, I think we've turned the corner in agriculture. We're getting close to the bottom. We probably haven't reached it in some areas. We're going to have to tough it out for the next two to four years. We're going to lose a lot of Senators -- probably me included; I don't know who else. But, you know, you're going to lose a lot of people in the process of turning this thing around.

But we are going to have to put agricultural trade -- because that's where the market's got to be; it's got to be abroad -- into a much larger context of the interdependence of this whole world. And the success stories of the people who have used the U.S. market have to be told, and the rest of the world, the fact that we are raising the standard of living of billions of people, and we've got to get something for it in exchange for it.

QUESTION: Another thing is our prices are way down, but you go to the stores, and what's the difference

between what the producer receives and what the stores receive, like 75 cents a hundred [inaudible] last year.

SENATOR DURENBERGER: Yes.

QUESTION: Versus close to 20 cents a pound in the store.

SENATOR DURENBERGER: Yes. Well, part of that is marketing, part of that is built-in costs, and part of it is just that some people aren't going to reduce their prices. I mean, when you look -- when I give my full-blown speech and I talk about the wonderful things we've done in the last six years, I say look at your American Express card compared to GMAC. You know, at least GMAC alleges you can now buy one of their cars for 2.9 percent.

But American Express is still charging you Carter's interest rates at 18.5 or 19.0 percent. So they're ripping you off, there's no question about it.

QUESTION: What can be done about it?

SENATOR DURENBERGER: Pardon?

QUESTION: What can be done about it?

SENATOR DURENBERGER: Well, you can pass legislation or you can quit buying. Information is one of the best things. If everybody goes around -- some politicians have been doing that since the last election -- going around saying, "I found a guy that will loan you credit card money at 12 percent or something like that, and

here's the telephone number."

Al D'Amato did that up in New York, you know. He had a telephone number for some company that was willing to lend money on purchases at 12 percent. So that's part of it. You've got to get some competition into the system.

QUESTION: Well, sir, I thought for a moment you were going to say the oxymoron --

SENATOR DURENBERGER: Oxymoron. Right.

QUESTION: I thought you maybe would have said entrepreneur, and we threw that out. But now I have just at this moment, motherhood, and you know, everybody wants to see what we have as surrogate, and I just happened to see that the point is I am standing here as a female per se and my motherhood has not been disturbed, but if you're going to be a surrogate father I'm going to say it's buffet-style, folks.

[Laughter.]

SENATOR DURENBERGER: You've been waiting to make that speech.

[Laughter.]

QUESTION: No, I haven't. I'm a Midwesterner and I'm a dairy farmer's wife and we just sold it because I didn't die of cancer and I'm an entrepreneur. No, I am not. I did say survival is the way it is. I honor the fact that you can stand there and talk before I do, then it's your

turn and then my turn.

SENATOR DURENBERGER: Right.

QUESTION: That's the game. It's buffet-style, folks.

SENATOR DURENBERGER: That's correct.

Where are you from?

QUESTION: I actually came from the same place you did.

SENATOR DURENBERGER: Where?

QUESTION: In the beginning.

SENATOR DURENBERGER: Stearns County?

QUESTION: No. You say farther than that.

[Laughter.]

QUESTION: But then we're in a new world and your mother gave birth to you, my mother gave birth to me, but I said a surrogate father. I'm saying things that are new, aren't I?

SENATOR DURENBERGER: Oh, great. Yeah.

QUESTION: Uh-huh. What I am saying is actually I have always been a German woman, misplaced, haven't I? Germany? Came to me, Schmidt, with Helmut. He's 17th cousin. They sent over a few of their college students that wanted to keep him in. He didn't stay in five years ago. And the world hasn't stopped, has it?

SENATOR DURENBERGER: No.

QUESTION: When I die, it's not going to stop. And my children are not going to shoot themselves like we shoot ourselves because the dairy didn't make it. You know what we did? We borrowed from Beethoven, Mozart, and we're concert pianists. And I don't know how to sing. I just listen and they do the playing at home.

[Laughter.]

QUESTION: It's buffet-style, folks. It's buffet-style.

[Laughter and applause.]

SENATOR DURENBERGER: You've got one last one?

QUESTION: You made the indication that you saw the agriculture turned around, maybe we're not quite on the bottom yet but we have turned the corner. Could you relate to me what indicators you have that gave you that?

SENATOR DURENBERGER: Those are gut feelings.

The question is you said that I think agriculture is turning around and we haven't quite reached bottom and so forth, and what are the indicators?

I think at this point in large part it is a combination of gut feeling and the search to put economic realities together with values. As I listen to people --

[Whereupon, the tape recording of the presentation ended.]

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided by the
Outpatient Ophthalmic Surgery Society
Pursuant to a Subpoena Duces Tecum
of the U.S. Senate Select Committee on Ethics

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THE MODERATOR: ...small change by the outpatient surgery centers, which we showed him that -- we brought him in tardily, so that the opportunity to visit with him in reference to signing books will only occur after the speech at 12:30. We couldn't get here by 11:00 to do it.

It is a delight to introduce my -- our Vice President, who will take over from now. Jerry.

VICE PRESIDENT: Good morning, ladies and gentlemen. It is really a great pleasure and a privilege for me to be able to introduce to you Senator David Durenberger.

As you may know, in 1982 Senator Durenberger became the first Minnesota Republican to be elected to the Senate in three decades, and he has earned the reputation as an innovator in redefining the role of government and as a leader in efforts to make public services more efficient and more responsive to the people's needs.

Senator Durenberger is perhaps known nationally for his role as the Chairman of the Senate Intelligence Committee. However, he is also on the Finance Committee,

the Committee on Government Affairs, and several other committees as well.

Now, we here in ophthalmology best know and appreciate Senator Durenberger for his activities as Chairman of the Senate Finance Subcommittee on Health. From this position he has led the drive to improve the nation's health care system through increased efficiency, increased competition, and consumer choice.

He was instrumental in developing the Medicare prospective payment system and the program through which Medicare beneficiaries can enroll in HMOs. He has been a principal involved in virtually every piece of health legislation which has been adopted by the Congress in this decade.

He is also the author of an exceptional book. It is called Prescription for Change: Health Care Reform Through Consumer Choice, and I recommend this book to each of you as required reading, and as a matter of fact we have a special opportunity because the Senator will be happy to sign copies of this book in this registration area out here immediately after his speech.

Now, the Ophthalmic Outpatient Surgery Society has a rather special relationship with Senator Durenberger. In March of 1985 he visited with us at our meeting in Dallas. We knew a little bit about him, and I think he knew

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almost nothing about us at that time. We spoke to him about some of our concerns that ophthalmic ASCs provided a means of providing eye care to our elderly at reduced costs, that Medicare was wasting hundreds of millions of dollars in excess payments to the hospital outpatient departments, and that the government should expand the incentives for the establishment of ambulatory surgery centers.

Our meeting in Dallas commenced a real revolution in this area because within weeks Senator Durenberger's staff was working with OOSS to develop legislation to accomplish these objectives and within months he had secured passage of this legislation in the Senate. Although the bill was narrowly defeated as far as enactment last year, he will introduce a revised bill in the next few days, which has an excellent chance of becoming law. I am certain he will tell us about this.

This is not to say that we don't differ on some issues with Senator Durenberger, but what distinguishes him in my mind from others is that he has a commitment to innovation, a willingness to listen to us and to try to implement new and exciting ideas, and in an era of cost containment, with an eye toward maintenance of quality care, ophthalmic surgery as outpatient surgery is one such innovation.

Senator, on behalf of Cooper Vision and the

Outpatient Ophthalmic Surgical Society, I would like to thank you for coming and to thank you for all you have done thus far.

Senator Durenberger.

(Applause.)

SENATOR DURENBERGER: Is this working? I went by here after breakfast. They said it wasn't working. I said that is fine. Probably I will get to the people in the front row who really want to hear what I have to say, and the people in the back row can think about what they are going to do after lunch.

Well, it is a pleasure to be here. It is great to come to California. I rode out on a Northwest Airlines plane last night with a lady who was going back to San Diego from Minnesota, and as we were in the airport waiting to get on the plane we were having a big tornado in Minnesota and when we got on the plane she said that is nothing, said wait till you get to San Diego, we have earthquakes, and I said, well, I will take my chances, what time of the day do they come?

(Laughter.)

Somebody told me this morning around 11:00 o'clock. So I must have missed the earthquake.

It is a pleasure to come back. A larger group than we had in Dallas. I don't know whether that is good

for the industry or just means that the things that we don't agree on have brought out more people. I am not sure which it might be.

(Laughter.)

So I got here last night, and I got up early this morning and I went over to the coffee shop and I sat there and listened to three ophthalmologists talking. I found that very interesting. Then I came over here. You can be incognito before you have to stand up and be introduced as a Senator, and that is one of the things that I enjoy very much about going to these conferences where I am sort of outside my own territory and away from where people will recognize me as the Chairman of the Senate Intelligence Committee.

Now, "Senate intelligence" you know -- I told you last year -- is an oxymoron.

(Laughter.)

For those of you who don't know what an oxymoron is, that is two words that are mutually inconsistent. "Senate intelligence" is one of those.

(Laughter.)

"Hospital outpatient" is another.

(Laughter and applause.)

I don't know, it seems inconsistent.

And as I told you last year, I also in my

previous term was on Senate Ethics, and some people --

(Laughter.)

So this morning I got out to see the real world, and I met Bob Penner over at his place and just came from Alan Perrin's place, and at Bob's I got to run a Yagg laser and they wouldn't let me run it on anybody in particular, but it is the first time I had ever really been through the surgical suite and seen all the rest of it and got to play with some of the very expensive equipment, for which you are all inadequately reimbursed.

(Laughter and applause.)

I have a large -- none of this is promises. This is just reactions. By this afternoon --

(Laughter.)

This afternoon I may change my mind. It has nothing to do with how many books you buy, but here I always --

(Laughter.)

I find that reporters have one thing that I can agree with, and that is they got little books like this and they go around taking copious notes. In the case of reporters what they take down in notes from a conversation never appears in print, but in my case this is the basis on which we go back and make a whole heck of a lot of judgments, and so I just share with you that I have learned

a lot this morning, and that, too, has helped to make this trip very worthwhile.

But to put what I am going to say about outpatient surgery and reimbursement, and so forth, in perspective, I need to step back just a little bit to the beginning of this week when I was one of the possible members of the Tax Conference Committee when it was still thought possible that all 20 members of the Finance Committee would go to the -- be part of the conference. There were just all kinds of people lined up outside my door wanting to talk to me.

By Monday evening it became clear that Bob Packwood was going to use seniority and he was not going to take everybody from the committee, only five members on the Republican side out of 10, and on a seniority basis that cuts off in 1976 and I got elected in '78. So I didn't make it. The lines disappeared, fortunately. There was nobody there.

Even though, the next day, on Tuesday, on Tuesday we voted. I was one of 11 people -- because we had to wait an extra half hour to get a quorum -- who voted to raise the national debt ceiling to $2.338 trillion, and I wish there was some easy way to illustrate it. If I had a PR person working for me, I would now have a slide that would show you what $2.338 trillion looks like. Stacked vertically,

hopefully it would go around the world a million times or something like that. I don't know.

But I looked at it on the resolution. We each had a xerox copy of the resolution which we were voting on, and I turned to John Heinz, who was next to me, and I said, John, do you think anybody is frightened by that? And he said, no, I think most people looking at that figure, even written out, you know, wouldn't understand it. You know, they would say why not add three more zeroes or four more zeroes. What does it mean?

(Laughter.)

What in the world does it mean?

The significance, though, of telling you that story is not to stand here and be proud that the fact from 1978 to 1986, my eight years in the Senate, we have increased the national debt from $800 billion to $2.338 trillion -- I am hardly going to brag about that -- is to tell you that there was nobody standing outside the door. They weren't lined up out there to influence my decision.

So where are they? Where are you? Where are you on the issue of debt and deficit and living beyond our means?

Well, a lot of us feel there isn't anything we can do about it. That is one of the problems. If I were to take a survey in here as to what is the biggest problem the

Congress ought to pay attention to, it would probably not be tax reform. Even though there might be an appeal in a two-bracket 27/15/33 corporate, et cetera, rate, I suspect in this room it would not be tax reform.

I think it would be the deficit. If I had a show of hands right now, I bet you 95 percent of the hands would go up in the room and the other 5 percent are divided between Nicaragua and South Africa probably.

See, now that is true, but why? Where were the lines? Why aren't people beating up on me?

Well, I don't know that it is appropriate to try to answer that question other than in the positive, other than even if there isn't a line outside the door on the morning we raised it to 2.338 billion -- trillion -- can't even remember the figure -- what are we going to do about it and do I feel any sense of responsibility?

I ought to have all hundred of us up here so we could all tell you whether we feel a sense of responsibility, but you only got one.

When I came to the Senate, Bill Proxmire, who is my neighbor from Wisconsin -- been there for 20 years -- he said, this is a great place to be, you will love it here. And I said, why? And he said, well, every morning -- says there is a hundred of us, and he says every morning I look at myself in the mirror and I say thank god that my sign

does not say the buck stops here; my sign says the buck does not stop here.

Now, that is not a pejorative on -- that is not Bill Proxmire. That is Gaylord Nelson in case any of you from Wisconsin are going to go back and rat on me. But it is not a pejorative on Gaylord, even though he left in 1980 because he was replaced by a Republican. It is an impression that most people have about the Senate and the Congress, anyway, that we all have those signs up there that says the buck does not stop here.

Last year when I was here I told you about the Alamo and why there -- were there so many heroes at the Alamo, because there was no back door. Remember that? And even the folks from Texas laugh at that because they know they were all folks from Tennessee inside the Alamo.

(Laughter.)

And then told you how the Congress is much like the Alamo with a back door and how every even numbered year we walk out one at a time and we go back to our constituencies and we tell them how great we are and how if it weren't for the rest of the guys in the Alamo we would solve all the problems, and you all know that your Congressmen and your Senators are just like that.

So you wonder how in the world you are ever going to get the buck to stop in front of every one of us so we do

something about the deficit.

Now, let me quickly say that the answer to that is really in how you and I perceive the problem of the deficit. Some people -- Ronald Reagan I believe is one of them -- believe that the deficit is a temporary phenomenon that somehow can be taken care of as soon as we do tax reform and spending reform and get the government turned around, and so forth. Then a healthy, optimistic economy in this country will bring the difference between what we spend and what we raise together.

There are other people, including some of the President's advisers, who do not care about debt. They say it is better to borrow than it is to tax. Don Regan happens to be one of those. Besides being a sexist, Don is also --

(Laughter.)

-- also believes that it is better to borrow than it is to tax.

But the vast majority of people, the vast majority of people have been using Proposition 13, which is a famous California phenomenon -- that is, if you want them to change spending, don't give them any tax money -- as a political tool, and that is what leading us into the deficit.

The idea that we could raise defense spending, not touch Social Security, and reduce taxes by as much as we

did can't lead you to anything other than a deficit.

Now, Art Laffer if he were here might debate me on that subject, but I have six years of history to prove that that is all -- that is where it leads.

So if the theory has been that we are going to cut spending and we are going to reduce spending and we are going to change the way we spend money by not feeding the animal with tax money, then I am not sure that that is working.

The reality is, though, to some degree it is working. The deficit is forcing us to cut money here and cut money there. But we are down to the point where people in this room believe today that we are taking money away from you and your efficiency and your contribution to the health care of this country in order to fill the gap between our current ability to raise taxes and our desire to spend money.

And you are just the latest to join the crowd. It started with senior citizens who thought we were going to cut back Social Security while we raised defense spending and cut taxes and we were going to balance it on their back, and for six years people have been joining the crowd and so you are just the latest, I think, to get on board the belief that somehow or other you are going to be forced by the deficit to take less for what you do.

So now we have all of these people joining in this chorus of do something about the deficit, and we still don't have anybody doing anything about it. But let me suggest to you that the reason is very simply that the problem is not just the difference between spending and taxing at the federal level. It is a larger problem in this country, and that is the inability of my generation to learn to live within its means, and that is more of a value problem than it is an economic or a fiscal or a monetary problem.

I believe that I have the right to smoke three and four packs of cigarettes a day and somebody will give me an artificial heart. In fact, I have a right to it. That is what I believe, and I am 51 years of age now. Hard to believe, I am sure, but --

(Laughter.)

-- that is what I am led to believe.

Don't make me wear a helmet or a seat belt or anything else, but make sure that I have got that insurance policy when I go to work for you that makes sure that I have a right with every ache and pain to a rescue mission of some kind.

We could spend more time on this subject, but we don't have time. We want to get to the Q and A.

It is my belief -- and I think it is a broad

belief in the Congress of the United States, and I know it is the belief out here -- that this really is largely a problem of values, that somehow or other my generation has been led to believe that we don't have to live within our means, and that leads us to not taking any responsibility for our actions, and that one could start us on an hour's discussion because whether it is health care or it is the Bill Moyers special of the poor black kids trapped in the ghetto playing mommy and daddy without any responsibility for it, you can go anywhere with the sense that not living within my means and not taking responsibilities for my actions has created problems in this country, and I think it is largely those kinds of problems that today we are having to learn to deal with in this society.

Now, is the Congress of the United States ready to step up and start to deal with these problems? The answer to that is, yes, we are ready, but we aren't adequately armed. We aren't adequately armed because we are still going to debate the difference between spending and taxes as a problem or a non-problem.

We put Gramm-Rudman-Hollings in place last year so that we didn't have to make all the tough decisions that would get us to a balanced budget. We didn't have to face up to having to raise taxes. We didn't have to face up to the various constituencies that reduce spending by the

difference between 200 -- or by $200 billion. So we put the automatic vegematic in place to do it. If the Supreme Court says it is illegal or unconstitutional next week, we deal with a more constitutional mechanism.

So is the Senate, for example, and the Congress as a whole, in my opinion, willing to deal with the issue of the deficit? I believe we are, but largely today in a mechanistic sense. We need a vegematic back there to back us up if we can't make all of the tough decisions.

But are we willing to put the vegematic there and take the heat for it? The answer to that is yes. We are willing to do that. We are willing to do that.

Now, in the context of balancing the budget, in the context of living within our means, in the context of taking responsibility for our actions, the politicians are always the last to join the crowd. If you want to start living within your means and you want to start taking some responsibility, we will follow. That is why it was such a pleasure for me to go to Dallas last year and to meet with an organization of physicians and their associates who are committed to taking responsibility for their decisions.

In advance of our switching Medicare from a cost-based reimbursement system to a prospectively priced system, you people told us that is the only way to go. If you want quality in your health care, if you want quality in the

decisionmaking relationship between a patient and a physician and if you also want some quality in resource allocation, then prospectively price what you are doing and don't insist on one set of prices if you are in this setting and another one if you are there and another one if you are here. Put a price on the procedure.

And I learned a lot last year about how we as a nation ought to be pricing reform in health care delivery, and I put that into the outpatient surgery bill and we passed it through the Senate last year, and it died in reconciliation because we couldn't get the savings that everybody told us we were going to have.

I came to Dallas, and Doug down here gave me all these ads from Florida, where the hospitals were ripping him off and all that sort of thing, and I said, my god, the Inspector General is right, there must be $5 billion in savings. Well, when we got to Washington, they told us there was only $100 million in savings, and that was all from reduced utilization, and so we lost on the fact that we didn't have enough savings in it. We lost on it because I had insisted on putting in co-pays for both ambulatory surgery centers, which you didn't have, for both the facilities and the physicians, and we lost on some technical objections from HCFA.

So this year in 1986 we put the bill back in

again, and on Tuesday or Wednesday of next week it will be incorporated, or most of it will be incorporated into the reconciliation bill that the Senate will pass next week.

In the portions of the bill that are incorporated, and beyond what was in my bill -- some of these things I don't necessarily advocate, and I know that you don't all of them either, but I will give you a capsule of what I expect is probably going to be in reconciliation next Tuesday.

There will be that effective July 1 of next year hospitals will not receive any more payment than will ambulatory surgery centers. The CRNA, anesthesia, and the direct medical education costs will continue to be -- they will not be changed in any way. We are going to do a two-year study of the direct medical education or the graduate medical education component for ambulatory surgery centers so that we know what kind of a figure we should contribute to medical education.

The ASC rates will be updated by -- we will have all the information in hand by January 1 of next year to get the '82 data updated to 1986, and that data will be used in the July 1, 1987 rate changes. Thereafter the Secretary will be required to update the data that he uses on an annual basis. Annually, also, the Secretary will be required to add procedures to -- that quality for ambulatory

surgery. Rather than doing it when he feels like it, he is going to be required each year to approve appropriate additional procedures which can be performed in an ambulatory surgery setting.

On the issue of co-pays we -- at least at this stage, unless you beat me -- have a compromise. We will have a 20 percent facility co-pay but no co-pay on the physician. The issue of whether or not you can waive the facility co-pay is left in the air. It was suggested that we put the right to waive the co-pay on the facility into reconciliation. Bob Packwood wouldn't have it there. So we are going to take up that issue when we do the fraud and abuse bill in committee in September.

On the red hot issue of peer review, I got to say I learned more at breakfast this morning and during the course of the morning than I learned before I came here. So I can't predict exactly how that one is going to turn out except I will tell you what is in the blue book that Mike Romanski has right now to look at that we are going to work at on Tuesday and Wednesday. That is, as you know, that on peer review for hospitals we have changed some of the requirements on hospital peer review, and we have also required that HCFA identify 10 special procedures that they are going to concentrate on determining medical necessity and everybody assumes cataracts one of them.

But here is the way the Chairman Bob Packwood's recommendations are right now with regard to peer review of medical necessity and of quality. Generally, peer review for outpatient procedures would not go into effect until 1989, but it would go into effect in 1989 with the Secretary having the right to try to make up his mind between now and the end of 1988 as to whether or not that ought to be pre- or post-operative. I haven't been able to find anybody yet in this room that thinks we can do preoperative medical necessity review, but if there is anybody here other than your leadership, you can meet me in the hall afterwards and talk to me about that.

The exception to this is cataract surgery. As of January -- this is the Chairman's recommendation -- as of January 1 of 1987 there will be pre-admission medical necessity screening by peer review organizations of cataract surgery. Now, that is the Chairman's recommendation. I joined in it before I got here. I have to honestly say about half of this notebook is filled with the arguments why that isn't going to work with regard to medical necessity on cataract surgery. So we will go back and we will try to find out how that one actually comes out.

On the broader subject of physician prospective payment, the reconciliation bill on the Senate side will also include the beginning of the implementation of a

physician fee schedule on a prospective basis. We don't expect to be able to have a fee schedule in place until 1991, but the work is underway now. We have -- I put a surgeon on the Physician Payment Review Commission, and the work is underway right now to try to come up with appropriate physician prospective payment fee schedules on the RVS, or relative value scale, system by 1991.

In the interim, however, you are all aware -- and if you aren't, I am informing you -- of the fact that within the next couple or three weeks the Administrator of HCFA is going to come out with a redefinition of "inherently reasonable" as it applies to some of the procedures, in particular the cataract surgery procedures, for physician payment. Because he announced it ahead of time by putting cataract surgery in the category of overpriced procedures, the assumption is that he is going to come out with a recommendation to reduce the physician payment by -- somebody told me this morning somewhere between 30 and 40 percent. I have no idea. I am just passing that on as a bad rumor, but I don't know what he intends to do.

Now, what is the premise that he is operating on? Well, he is operating on the premise that in 1978 -- or from 1978 to 1983 Medicare physician payments increased by 20 percent, 1984 Medicare physician payments increased by 12 percent, 1985 they increased by 10 percent, and this is all

despite the fact that in the last two years we have had a Part B fee freeze on. So he says they got to be making money someplace. So they look at overpriced procedures.

We had a hearing on all of this on April 25th, as soon as he made that announcement.

So they are operating on the theory that this set of overpriced procedures in one way or another needs to be attacked.

Now, the question mainly is how are you going to go after the so-called overpriced procedures. I won't try to discuss or debate with you until we get to the Q and A here how you may be specifically affected, but there is two ways to go after overpriced, so-called overpriced procedures. One is to cut everybody by 30 percent, or something, who does -- or cut all cataract surgery payments by a flat percent, and the other is to recognize how some of the inequities in physician payment within the current CPR, or customary prevailing reasonable, system got in there and where they exist. One is on the -- and I am telling you this because in reconciliation my bill challenges the notion that the Administrator can arbitrarily reduce what he considers to be overpriced procedures across the board, and I challenged that and put in place a procedure by which we expect him -- if he can prove that he has a procedure that is generally overpriced, a procedure by which he needs to go

about changing the pricing.

In the case, for example, of cataract surgery and in the case of a whole lot of the CPR approach to financing physician reimbursement, you will find first you have a geographic problem. There is one reimbursement for cataract surgery with an interocular lens in California, a comparable one in New York, but a much smaller one in Maine or Vermont or an even smaller one in the State of Florida. So you go across the country and you find much the same sort of thing that we can find in other procedures, but there are geographic differences that are inexplicable just on the basis of ancillary costs and wages, and so forth.

Then you have the difference between the general practitioner and the specialist and the charges that are made there.

A third one of the contributions to the distortions in the CPR is the difference between the longtime physician and the brand new person on the block. The brand new person on the block doesn't have any history. That can then drag him down in the CPR; whereas, the person that has been at this for a long time has a history that gets in the way of determining what is a customary charge.

Then we get into the issues of cognitive versus surgery and the way in which payments are made on the basis of one or the other of those contributions to a particular

patient's procedure.

So what I tried to do in reconciliation, in my bill, is to say that if in fact we are going to go after identifying CPR changes for certain kinds of procedures that we need to look beyond the procedure itself and we need to look at some of these other factors. That is particularly true with regard to a surgical procedure such as cataracts, where we, the beneficiaries of cataract surgery, have gained so much from the advances in medical and high technology as applied to those procedures. We are now able to -- I mean the numbers, if it is a million a year or whatever it is that we are doing -- cataract surgery is only possible because you are so much better than you were 10 or 15 years ago, and if I can sit down there and look at my Yogg, Yagg, whatever this thing, you know, and I can just push a button, then, my god, you know, that is incredible. Everybody in America, particularly Bill Roper and Otis Bowen, ought to sit behind one of those things and watch that happen.

So the question is why penalize the accomplishments, not that we expect that when you come on the market at $2000 that there isn't some way that you can get down to $1000, but you have already gone way past that part of the issue. The issue right now is largely what society deems to be medical necessity.

When you didn't have the technology, when the

procedure was risky, when the rehabilitation took almost forever, then society had one definition of medical necessity. Today, when you can do the breakfast to lunch routine and -- as Dave McIntyre was telling me, he got lucky. He got the anchor person on the biggest television station who walked in at breakfast, left at lunch, and then that evening was on the 6:00 o'clock news bragging about McIntyre.

(Laughter.)

When that becomes society's standard of medical necessity, who am I, as the payor, to decide that I am being overcharged or that I am being overpriced because we have one million people today rather than 200,000 who are access to that service?

The assumption made in Washington largely is that if the numbers went up that rapidly, from 200,000 to a million, or whatever it is, that some of that must be unnecessary surgery.

So whether you approach this particular issue in terms of redefining medical necessity or you approach it -- which is a societal problem, or you approach it in terms of the budget, I come down on the side of helping society understand better the definition of medical necessity.

Now, you are going to see a lot of politicians trying to balance the budget on the backs of the skills and

the contributions that people in this room have made to medical technology, but you won't find me doing it.

If my parents, whether it is through an interocular lens or a cochlear implant or whatever, if my 80-year-old dad is going to be able to have one more day of a more pleasant life or one more month, or whatever, so he isn't a pain for my mom, or whatever justification, if he just likes himself better because of the improvements in medical technology, then that for me becomes an opportunity to readjust my view of medical necessity.

(Applause.)

And the folks on the other side, some of the folks at the American Medical Association and other places, are going to say there isn't enough money to go around. See? So why waste it on cochlear implant when we haven't got enough to go around? And I want to say -- I don't know whether this book tells you this or not, but I wouldn't be in the health policy reform business if I thought there was a shortage of financial resources to apply to the health of Americans.

(Applause.)

We are putting all the resources -- my generation -- and this gets back to the beginning, and I will end this -- we have been putting our resources in my generation in the wrong end, the wrong end. I don't have a price put on

staying healthy. I don't get a reward -- my generation -- for staying healthy.

What do you think we will have available to us if everybody was rewarded for staying healthy? If we put a larger share of our Gross National Product and put it into health care, think of how we would bring down the curve on sick care. You know it. Everybody in this room knows that. But how do you do it? How do you get this thing turned around?

We are in the process of doing it, and people like you, who have shown us how to do things better by doing them differently, are in the vanguard of accomplishing that. There are a lot of efficiencies if you look at it strictly in economic terms built into the health care system today if we who are in the third party payment business can just make it possible for those of you who are in charge of our health to find ways to keep us healthy and fix us up when something goes wrong.

So our cause in the largest part will be not to balance the perceived budget in this country by cutting spending or cutting into innovation, and so forth, but by releasing the opportunities for more Americans to have a greater access to the wonders that medical technology and the people who are the medical technology system in this country can bring to all of us.

I appreciate what you are doing. I am going to just wind this up with -- come on up, Mr. Chairman. You were, anyway -- I want to make -- because somebody asked me, said this organization was -- I think Bill probably asked me about PACs and things like that and what do I think of political action committees. I said, well, I am all for them because I ran twice for the Senate, both times against multi-millionaires, and both of them could out-spend me till the cows wouldn't come home, and the last one put $7.5 million of his own money into his campaign to beat me. I raised $4 million of your money and --

(Laughter.)

-- and won.

So, yes, I am all for PACs.

But then I said, Bill, you know the most important thing that you do is not the PAC. I mean, that is great and you really ought to do it, but the most important thing you do is you make Mitch McConnell and Wendell Ford a lot smarter in their view towards health policy in this country. I just picked on him because he is from Kentucky, and those two people.

The largest contribution you can make to the positive change in health policy in this country is educating your own member of Congress and your Senators. There are very few of us who are approaching expertise, if

you will -- and I am sure not -- in the area of health policy, very few of us. So what happens when these crucial issues come along, there is only a few of us that can make the difference. The rest of the guys are either staying out of the way or trying to balance the budget on the backs of cataract surgery or something like that.

You have an incredible responsibility, I think, to educate your own members of the Congress and the Senate, and I just advise you not to wait until a particular bill comes along but start that process today. When something is going on in your state, whether it is Medicaid or -- it doesn't even have to be a federal policy thing, just any opportunity to educate them or to educate their health assistants or something like that, take them like I did. I mean, it is the first time I ever put on the white suit and went through the surgery center and looked at the Yagg. Well, I should have done that years ago. Take them through that, give them the same kind of little brainwashing session that --

(Laughter.)

I mean it is not hard. These guys are experts. I mean your leadership are experts, but I think all of you can do this. I mean, you could talk to me about the difference in reimbursement between this particular procedure here or at the hospital, and you can talk to me

about the fact that the hospital gets a lot more for those Yaggs than you do and, you know, that is all simple, understandable. Any politician can understand some of those discrepancies, and you could make a wonderful contribution to the future of your practice, meaning the future of the people in your communities, if you would just take the time to get those people to understand better the difference between what you do and what traditional medicine, so-called, has been doing because you have got the answers for tomorrow. So do it.

(Applause.)

Thank you.

THE MODERATOR: If you will be seated, we will now have a question and answer period. In case we have a dissertation, I am going to take the President's, or Chairperson's role, and thank you for your question and go to the next one. So please state your name and then your question, and it will be answered.

Henry.

DR. HIRSCHMAN: My name is Henry Hirschman.

I find it very confusing that Medicare finds nothing inconsistent about paying either nothing or $504 or $3500 for identical outpatient surgical facility services, depending on whether it is an approved facility or a hospital-based facility, and yet if $100 of that surgical

fee were to change hands between two eye practitioners caring for that same patient they are threatening jail sentences for that.

Is there any way that we should get some clarity out of that?

I have another couple of points.

THE MODERATOR: Why don't you ask your second question later?

DR. HIRSCHMAN: All right.

SENATOR DURENBERGER: I think that was largely in the form of a statement.

First, there is -- we are going to cure the first part of that, so that your premise on which the second is built hopefully after reconciliation is gone. We are not going to differentiate in the facilities payments between hospitals and the others any longer.

But on the second one I take it that is part of the fraud and -- is that part of the fraud and abuse?

DR. HIRSCHMAN: The fraud and abuse thing, yes.

SENATOR DURENBERGER: Yes, and I am not going to justify it, but I indicated earlier that in September we are going to address the amendments on that bill, and I will find out exactly the nature of that problem and I believe we will correct it.

DR. HIRSCHMAN: It is hard to play the game when

you don't know where the boundaries are.

SENATOR DURENBERGER: Yes.

DR. HIRSCHMAN: One of the most encouraging things that the Reagan Administration introduced was the Grace Report, and this produced recommendations in great detail by an incredible group of people for how the government could save $400 billion and be within the thing -- things like not requiring reports that no one ever reads and various major things like that.

Is anything being done to support the implementation of the Grace Report? Is there any way that we could be helpful in that?

SENATOR DURENBERGER: The only way you can be helpful is to get very specific on a particular recommendation, and I am not asking you to do that now, but to get very specific on a particular recommendation, particularly that requires legislative action.

The bulk of the money savings in the Grace Commission Report, in dollars, came out of changes in entitlement programs, particularly pensions, Medicare -- they recommended the same thing I have been trying to do since 1982, and that is means test the Medicare system. So their large dollar savings come from entitlement reform.

You know last year Dave Stockman thought about one of those -- recommended one of those, which was why

should we be paying so much money to retire people from the service at age 42. Right when they are in the prime of their contributions to their country we bail them out of the service and have them start making contributions to their families and -- but we still have this incredible pension obligation to them, and he got shot down immediately.

Cap Weinberger -- I asked Cap Weinberger last year the same question you just asked me when he came to our Republican Caucus, and here is his -- his answer was that two-thirds of those recommendations which allegedly could have been done in the Defense Department administratively were either premised on -- they were either developed by people who had it in for the Defense Department, who had a record of having it in for the Defense Department or they were impractical. The other third he was already implementing.

So I imagine that has happened all the way up and down the line in the President's Cabinet.

So I have read the report, plus I read "Burning Money" -- I think the popular version of it -- and I would say that I liked about 90 percent of it and in terms of the pension and the health care and some of the other sides I am involved in some part of the redesign of that system.

THE MODERATOR: The other question?

DR. HIRSCHMAN: Okay. A suggestion, which is a

five-second one, and that is if representative government can be restored instead of government by federal bureaucracy regulations, we could take one lesson from the FDA, which is not our favorite group, and that is perhaps legislation could be -- would have to be determined to be safe and effective before it was introduced.

(Laughter and applause.)

THE MODERATOR: Question from the doctor here.

DR. BILLING: Okay. My question is a lot of us are doing --

THE MODERATOR: Your name, please?

DR. BILLING: Dr. Harvey Billing, from Templeton, California.

A lot of us are doing procedures in our ASCs that aren't covered on the present list and just do them for the convenience of the patients and don't get any reimbursement from anybody for them. But could we do and when do you foresee this new list coming out? I mean, we are --

SENATOR DURENBERGER: As I -- did everybody hear the question? I don't have to repeat the questions, right?

On the new list for the additional procedures they are supposed to be out right about now with some additions to that list. Under the reconciliation requirements, though, we are requiring that the Secretary has to do it every year, beginning -- I think it is January

-- I think January 1st of next year is like a deadline for him to bring out a new set of additional procedures, but then after that you can expect a new list each year, and you can also expect that the data for reimbursement purposes on which that list is premised will be annualized data as well.

Thank you.

THE MODERATOR: Question from the center.

Your name, please.

DR. BECKER: Yes. Dr. Stanley Becker, from St. Louis, Missouri.

I really appreciate your coming, Senator.

I have been practicing in St. Louis for 27 years, and there is something that has really concerned me about Medicare since its inception, and it is simply this. I can look outside my ambulatory surgery center and see patients who come to my office who come up in Cadillacs, Mercedes Benzes, and many other, and live in a very, very luxurious way and -- for instance, a gentleman was in my office who was scheduled for surgery just before I left who owns a ranch with 28 lakes on it.

I cannot understand why Medicare should pay these bills for these people when in fact they are among the wealthiest in the entire country. I can understand where medical care is a necessity for those who cannot afford it, who require their vision just for their daily existence, but

why should someone come to my surgery center who are extremely wealthy and have Medicare pay the bill and then they take that very same money that should have gone for their care and they will take a cruise.

SENATOR DURENBERGER: Okay.

DR. BECKER: To me I find that difficult to understand.

SENATOR DURENBERGER: Right. Yes, and the answer to that is because that is the way the law was designed in 1965, but the solution to the problem is to change the law.

I indicated in my comments that in 1982 I introduced a bill to means test the Medicare system, and on the theory that Social Security was a cash program and you were supposed to buy your health care in part with your Social Security cash and other things, and I have not been -- I am still around. I mean, I introduced it before I ran for reelection, and I made it through that election campaign, and I think it is only a matter of time and a quality product.

If you want to be practical about it, if we were to improve the Medicare product by putting in catastrophic, then we are -- and I can -- I am not going to try to explain how to do it, but we are going to get the recommendations in September about how to do it, but if we can put the catastrophic in there, the next step is means testing it.

The easy way to means test it is off of premiums. Drop the premiums down, combine Part A and Part B into one, so you are buying the health care package, not a separate one for the docs and a separate one for the hospitals, but one package, and you got a set of benefits, including major medical or catastrophic, and you have a premium which is low enough so that the low income people can afford to buy it off the premium. Then -- but everybody pays that low premium. Then you get the money back in my bill -- there are probably better ways to do this that the Secretary is working on now. In my bill we got the money back for the program off of, at that time, 1 percent of everyone's adjusted gross income on a tax return. Now, there might be better ways than requiring everybody to have a tax return, but you can set up a means tested Medicare program.

DR. BECKER: That was my one point, and whatever means is used to make that more equal of course would be beneficial.

The second item, which has always troubled me -- and you touched on this just briefly -- and that is in the same hospital and the same operating room two doctors are operating, both doing identical procedures on the same type of patient, and one is being reimbursed at a much different level than the other. I have never been able to understand that.

SENATOR DURENBERGER: Well, in the old days when the physicians told us that we ought to have a relative value system and a fee schedule, we told them that that was in violation of antitrust, and now we are begging them to take a relative value system and we will have one in place, as I said earlier, by 1991, and it will take appropriate -- it will be done by specialists and it will be done by a consultation method where you just get a bunch of people together and you work out what are the requirements by way of education and experience and what is the cognitive and what is all the rest of these sort of things that you understand and I don't, and we are going to put a fee schedule in.

DR. BECKER: One last thing. If they are going to save 30 or 40 percent and reduce the fee schedule which HCFA proposes, then it certainly would not be equitable, as you had suggested, for this fee across the board. Certainly those who have been charging excessively in the past should be the ones that are penalized the most.

SENATOR DURENBERGER: That is what we are trying to do in the interim, before we get to something that everybody can understand. In the interim, where they believe there is overpricing we are trying to get them to pin down -- not you cut everybody in a particular surgery, but you address the geographic differences, the old/young

differences, the specialist versus the general, and all that sort of thing.

DR. BECKER: I thank you very much.

THE MODERATOR: Question from this side of the room.

DR. GINSBERG: Yes. I am Dr. Arthur Ginsberg, from Dayton, Ohio.

Senator, I am sure everybody realized you covered two key areas here. One is the finances of patient care as well as the quality of life issue. Although you didn't want to emphasize the financial issue, I think it is important to recognize that it is the advances of these doctors that have actually kept Medicare costs down. It costs much more to take care of a patient who doesn't get proper eye care, having them in old folks homes and other types of practices, than if they do the implant operation, and I think people like Bill Sardie have developed a credible set of statistics to back up these things. These people have really kept down medical costs if you go beyond that myopic view of just the initial cataract surgery.

The second point, though, is the quality of life issue that you touched on that again I think everybody is considering to be quite important today. As we do get older the quality of life, such as your father and everyone else's father, becomes crucial, and we know you understand the

difference between some people having good vision, having 20/20 acuity, and some people not having good vision of 20/20 acuity, and the other point you raised was how can we educate these Senators and colleagues along those lines, and we talked with a number of doctors, and Dr. Zimbelli here has a pair of glasses that might demonstrate to you and your colleagues what it would really mean to have poor quality vision even though you might have good acuity.

THE MODERATOR: Please bring it forward.

Question -- well, while that is being done.

VOICE: Oh, here they are. If you will put these on. This is somebody that does have 20/20, test 20/20, and yet --

(Laughter.)

(Demonstration.)

(Applause.)

DR. GINSBERG: This, Senator, what it is is a material that is scattering --

(Simultaneous voices.)

DR. GINSBERG: It is scattering light, and this is really your problem of your cataract patient.

SENATOR DURENBERGER: Okay.

DR. GINSBERG: And I am sure if you give that to your colleagues and ask them if they would like their parents to go around with vision like that they might think

a little differently about cataract surgery.

(Applause.)

THE MODERATOR: Thank you, Senator, for allowing us to demonstrate that.

In the yellow shirt, name and your question.

DR. PARENT: Dr. Rex Parent, from Ft. Wayne, Indiana.

I have a specific question, in that we are involved in -- between our Medicare review and our Medicare certification, and I have talked to several other people at this meeting who have ambulatory surgery centers, and it seems to me like this is becoming a longer and longer period of time until you get your first reimbursement from Medicare, and I specifically called the Chicago area Medicare office and asked if I can be of any help, if we can fly up, if we can do anything, and one of the people said quite frankly we are overworked. And I don't know whether that is the problem or what the problem is, but I know that each individual I talk to that is in this state between review and reimbursement, that they say financially, you know, you are in quite a time of distress and that literally it really cramps the way that you think about doing things for the patient, which I don't think is legitimate.

SENATOR DURENBERGER: I don't think that is the problem. I think the problem is generated at the Office of

Management and Budget, and they are deliberately sitting on their hands, and the longer they take to approve you and the longer they take to pay your bills, the more money they have to put against this stupid deficit, and that is one of the things that clearly is going on right now.

So we have all, all of us who are involved in this sort of thing, have put together a prompt payment bill, which will also be incorporated into reconciliation. That isn't quite the issue that you are touching on in terms of the review/approval sort of thing. Some of that is overworking. I mean, some of that in particular -- a particular region. I can't talk about the Chicago region. I was in it two months ago on a Friday afternoon, unfortunately, and most of the folks were there. I was happy to --

(Laughter.)

I could have gone in a lot of other bureaucracies and they all would have taken off at 2:00 in the afternoon, but they were there working, and I sure appreciated that.

So maybe region by region you are getting some understaff problem, but in large part, as we have followed the overall payment issue, it has been done deliberately to make money.

DR. PARENT: How about is anything being done specifically, you feel, that this bill that you are talking

about will specifically address reimbursement after you have been certified? Because several people I talk to say you will get -- if you admit -- or send in 10 claims you will get one paid for and then you don't know when you will get the other five paid for.

SENATOR DURENBERGER: That is right. Our bill requires that 95 percent of your claims be paid within 21 days.

DR. PARENT: Thank you.

SENATOR DURENBERGER: You are welcome.

(Applause.)

THE MODERATOR: Question? Name and your question.

DR. BEEBE: Dr. Richard Beebe, Venice, Florida.

I wonder what effect the bill will have on the anesthesiologist in the outpatient surgery setting.

SENATOR DURENBERGER: You know, I am not sure I know the answer. You are talking about reconciliation?

DR. BEEBE: Yes.

SENATOR DURENBERGER: You want to get reimbursement back or --

DR. BEEBE: No.

SENATOR DURENBERGER: As far as the payment, as far as the --

DR. BEEBE: I am talking primarily about our

fees. If there is a reduction in cataract surgical fees, will there be a concomitant reduction in our anesthesia fees?

SENATOR DURENBERGER: Well, not that I am aware of.

Mike, do you know?

VOICE: Yes.

SENATOR DURENBERGER: There will be? They are going to cut anesthesiology, too?

VOICE: Your bill would direct HCFA to come up with some savings through reductions in payments for anesthetists doing standby local anesthesia.

SENATOR DURENBERGER: Okay.

VOICE: Excuse me, Senator Packwood's bill.

SENATOR DURENBERGER: Packwood's bill, yes. Okay.

THE MODERATOR: Question.

(Laughter.)

Jerry.

DR. FRIEDMAN: Jerry Friedman, from Memphis, Tennessee.

Senator, thank you for coming.

Dr. Ginsberg I think would like for you to know that those glasses that you were wearing would give you 20/20 vision although you are looking through a haze.

THE MODERATOR: Testable vision.

DR. FRIEDMAN: Testable vision.

My question is very simple and direct. Why can't Congress give our President line item veto powers?

SENATOR DURENBERGER: Well, I will tell you why I don't -- and I am probably right at this stage one of the swing votes -- because if the President had a -- if we had a Constitutional amendment to balance the budget, if the President were required to submit a balanced budget and the legislation to actually balance the budget, I would give him line item veto. Most of the governors in the country have a line item veto.

Absent the requirement that he balance the budget with that line item veto, I am not going to give it to him because he is going to use it against my vote on Contra aid or something else. So that is why I have voted against it.

DR. FRIEDMAN: Yes, what would the President agree to again?

SENATOR DURENBERGER: Oh, if the President would agree to always submit a balanced budget or if we had a Constitutional amendment to require the President to submit a balanced budget and the Congress to pass a balanced budget, then line item veto is appropriate. But the important thing is the balanced budget, not the line item veto.

So in other words, conform the federal system with the state system. Governors have to balance their budgets. State legislatures have to balance their budgets. They also have line item to do that. But if you don't have that balanced budget requirement in there, then a President can use the line item veto to threaten me on an irrelevant vote that has nothing to do with the balancing of the budget.

THE MODERATOR: Senator, I believe Jerry is going to call President Reagan right now.

(Laughter.)

Question in the center.

DR. MINNICKS: Mark Minnicks, from Paintsville, Kentucky.

I want to go back again to reimbursal. It is not philosophical, but maybe we could solve this problem.

As an incentive for ASCs, wouldn't it be possible that -- when Medicare provides licensure, couldn't we at the same time be provided the vendor number instead of waiting three months or four months to be repaid for the services which are rendered?

In other words, currently Medicare comes in and approves a facility. They say go ahead and operate, it is okay. Two months later you receive the vendor number, and so three or four months later then you receive the

reimbursal.

So wouldn't it be much easier just to at the same time, simultaneously, have the license number and the vendor number and save a lot of pain?

(Applause.)

SENATOR DURENBERGER: Okay. Thank you very much.

THE MODERATOR: This will be the last question.

SENATOR DURENBERGER: You got two guys up here.

THE MODERATOR: The last of two questions.

SENATOR DURENBERGER: Or three.

DR. DOMIANNO: Richard Domianno, from Denver, Colorado.

Regarding inequities region by region, I am a corneal transplant surgeon and often we can do patients in an outpatient setting even though corneal transplants are not on the approved list by doing them along with a cataract or an interocular lens exchange. There is an inequity in that the tissue for the corneal transplant is not being reimbursed by Medicare without some magic number that we cannot possibly find. They will do it in Rochester, New York, but they won't do it anywhere else throughout the country, to the best of my knowledge.

SENATOR DURENBERGER: Thank you. I will try to get an answer to that.

DR. DOMIANNO: Thank you.

THE MODERATOR: Name and question.

DR. SCHEFLER: Yes. My name is Lou Schefler, and I am a corporate sponsor of OOSS Medical Consulting in Montville, New Jersey.

There are only 24 states that allow for these types of facilities in a big way because they don't have certificate of need laws, and the other certificate of need law states have obstructionist kind of policies that are holding back because of hospital lobbies, and I was wondering if there was anything that could be done on a federal level in terms of getting the states to move on -- moving on that?

SENATOR DURENBERGER: Yes. I am building that right now.

(Applause.)

Thank you. I am building that into -- I mean, I have got -- I mean, I know what to do. This wasn't the year to get it done. Once we got over the hurdle on capital, which we will get done this year, on hospital capital, and we are at the national averaging on reimbursement, then I intend to -- maybe by next year we can get it done. Just make sure that, number one, we don't want -- I don't want certificate of need, and if certificate of need is used in any way to discriminate against alternate facilities, then they don't -- then they aren't going to be eligible in their

state for reimbursement. That is the way to do it. I mean, it is just ridiculous -- or even to use certificate of need to require the utilization of hospital specification in the construction of ambulatory surgery centers. I mean, you don't -- that is a ridiculous way to use the CON process as well.

That is the last question over there.

THE MODERATOR: Question.

DR. CHAUTNER: Yes, Senator, Dr. Brainerd Chautner from Harrisburg, Pennsylvania.

I have one question regarding peer review and utilization. You alluded to the fact that you would like your father to be able to have surgery. I am on Blue Shield's advisory board in Pennsylvania. The girls who currently sit -- the staff that currently sits on the peer review organization, when I informed them that I believed we were going to get 100 percent cataract review in January, they had a fit. They are overworked as it is now.

My question to you is have you or has Congress or has anyone in HCFA considered the idea of an affordable, but meaningful co-pay with enough contingencies so that those people who couldn't afford it would be able to get the care, but have you considered a small, but meaningful co-pay to allow the patients to decide whether or not seeing better -- for instance, in the case of cataract surgery -- would be

worth whatever that small co-pay was?

That would be a control --

SENATOR DURENBERGER: The answer to that is yes. This organization hasn't supported it, but, yes, I am a strong believer in co-pays, and reconciliation will have a facility co-pay in it. I like it not just for the reason you suggest, but because I think people will be a little more selective between really good medical providers and those that may not be, at least reputed to be, as good.

But that doesn't solve the problem of peer review. We still have to make a decision between now and the first of January on how practical it is to take the peer review process in the current condition that it is in around this country and apply that to preadmission screening of medical necessity on cataract surgery.

DR. CHAUTNER: It would be a nightmare.

SENATOR DURENBERGER: I mean, I am not convinced of anything at this, but I am certainly persuaded by what I heard this morning that that is going to be very difficult to accomplish. There are some alternatives that were suggested to me, including AAAC and some other built-in kinds of procedures, and I think what some of your colleagues here were saying was that maybe what we ought to do in the whole issue of medical necessity and who is doing inappropriate procedures or something like that is to

validate the surgeon, not try to validate each procedure.

DR. CHAUTNER: Right.

(Applause.)

THE MODERATOR: In closing, I would like to bring reference to the fact that Henry Clay, the famous Senator from my State of Kentucky, was again acknowledged as one of the great Senators of all times. In discussing this at home with one of my children, Adam, I was trying to explain what made Senator Henry Clay what he was to our country, and I stumbled, but I certainly have a solution based on my several hours with the Senator. I think that Adam ought to get to know Senator Durenberger.

Thank you very much for coming.

(Applause.)

(Whereupon, the meeting was adjourned.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
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by Senator David Durenberger

March 18, 1986

Owens-Ill.

Discussion on Health Care, Nursing Homes

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SENATOR DURENBERGER: [Inaudible] with us over the next couple or three years [inaudible].

The [inaudible] in terms of my bona fides in being here, those of you who are interested in where we're headed in national security policy might want to pick up a copy of a book I wrote. Actually I wrote this in draft form for my constituents back in 1982 when I was running for reelection. A marine, former marine publisher saw it and convinced me I ought to put it into a book. But it's called Neither Madmen nor Messiah. But it's available, I think, in most B. Dalton Booksellers [inaudible]. But it is, in effect, a strategy for developing national security policy.

I am now doing that on the intelligence side, and Barry Goldwater, who has read that from cover to cover the week it came out, and Sam Nunn is doing it on the Armed Services side.

And eventually, probably in a matter of four or five years, we will have a national security policy in this country with a strategy that has a defense element to it and an intelligence element to it and a foreign policy element to it and so forth.

And the reason we are moving in that direction is for consistency and for focus and for efficiency in tha

utilization of our dollars and our other kinds of resources. Now, that is the same theory, I guess, that is behind health system reform, will eventually be behind the reform of infant security in the country when we tackle issues like retirement, disability, and tackle the issue of welfare reform and how the country puts a better safety net under its less-advantaged and all that stuff.

Anyway, we are in the era of reform. Having learned that there isn't any problem we can't solve in this country, we are now in the process of finding better ways to solve than by spending money on it. And right now that is the '80s, the real '80s revolution, is not getting government out of the domestic services business and it is not getting the national government out and dumping everything on the States, it is finding better ways and better combinations for financing these levels of public services in general.

The President talks, as you know, about private sector initiatives and all that sort of thing. And what he's saying, I think, when he does that -- and I am not sure he understands it fully, but probably better than a lot of other people -- but what he is saying, in effect, is that with some rare exceptions there aren't any services in this country that can't be produced by a for-profit institution of some kind, that we have created the nonprofit

institutions in this country as a way to subsidize certain kinds of services and the way we create government to subsidize certain kinds of services that the for-profit system couldn't deliver.

But that doesn't make profit bad, it just makes it less [inaudible]. The risk is not as available in the for-profit sector as it has been in the public sector. But that is only because we have been reaching for invention, we have been reaching for a new way to do this and a new way to do that. And while there is a certain amount of risk-taking in the so-called private sector in private goods and services, there has never been enough risk-taking in health, education, and welfare and so forth, other than in the employee fringe benefit area, so that we could ever do without the nonprofit corporation or the government.

Now, I would argue that the nonprofit corporation's days are numbered in America. Some day I will find the time to write that up someplace so people can laugh at it.

But it is very appropriate for you to think about it in that context and try to be helpful because I presume, without knowing, that that issue is the essence of why we are going down into the long-term business. You have the precedent of proprietary and nonproprietary, so that there would be some encouragement that you could come in and if

you were good you could make some money. But the reality is that there is no any longer any reason for hiding subsidies in the -- under the aegis of 501(c)(3) for most of the services.

Institutions, in an era in which value and efficiencies are wrapped together, trying to save money and also deliver quality products, in that kind of an era there really is no longer any reason for hiding the subsidy. Subsidies really ought to be as explicit as possible so people can shift from one institution to another. So the only way to do that in just the corporate arrangement is to get rid of the notion of the nonprofit corporation to provide something like long-term care -- to stick with your example, just for the sake of debate.

Now, you may want to say that shelter services for the elderly is a public [inaudible] whether certain kinds of health care for the elderly is a public purpose. Okay. And we would like to subsidize the access for that to make sure that there is enough shelter around and there is enough service around.

The question is: Would you, if you were starting from scratch in 1986, would you start the process by creating an open invitation to anybody who wants to go into the 501(c)(3) rest home business to do that? Or would you say, "I am going to provide every person in this country

over such-and-such an age with such-and-such a condition with a dollar-denominated right to make a choice of this set of services"? And I would choose the latter, for the same reason that I would do that when I buy an automobile [inaudible] or in painters or beverages or anything else. I find the marketplace by empowering the consumer to make the decision. I don't get to a marketplace by giving all my money to providers and saying, "Anybody who wants to go into the glass bottle business gets to go into the glass bottle business, and we offer subsidy to do it." Where the hell would we ever get the efficiencies out of that kind of a system?

So the same theories apply in any denominated set of public services. I mean, we're doing it all over the place now from garbage collection to food service management, anything. We can do it in education, we can do it everywhere. There is no reason -- as long as you look at it in terms of who should get the money and where should the subsidies be. You can't tell I am a great believer in consumer finance, consumer choice in the delivery of services. And when I am given my druthers of where, how high to take a subsidy dollar and put it into the system for efficiency, I would give it to the consumer.

John Brademas, former congressman, who is president of NYU, was in to see me the other day on

tax-exempt bond financing. And he is complaining that the way I have structured the remedies to tax-exempt bond financing, that I am making it difficult for him at NYU because they have such a small endowment, they take care of all these low-income people and all that sort of thing, and that I should -- I should free him up to get as much tax-exempt bond financing as he could possibly get. And I have a cap on it that no institution should be able to have more than $150 million ink tax-exempt bond finance out at any one time, tax-exempt finance bonds.

He says that would discriminate against NYU, one of the biggest private colleges in the country, would discriminate against it. I said, "John, you know, if I were going to use a 35 percent subsidy against $150 million worth of bonds" -- [inaudible] figure it out, whatever it is, $50-60 million worth of subsidies -- I said, "I wouldn't give it to you. I would give it to those poor kids in New York and let them decide whether they're going to NYU or CUNY or one of these other places."

And he said, "Well, that's true, you know. I've only got a $19,000 per student endowment at CCNY or whatever it is [inaudible] and Harvard has a $2.6 million per [inaudible]."

And I said, "Well, so what? I mean, I am not in the business of preserving NYU any more than I should be in

the business of preserving, you know, outdated nursing homes because they are owned by some little town or even the public general hospital [inaudible]. Why should I preserve a hospital just because it's here if somebody else can go into the service delivery business providing a lower price?"

Now, there are arguments you can make about transition and things like that, but that is just to facilitate your understanding of how I feel about the choices of subsidy.

And you can take the notion of subsidy and you can take it into a lot of areas. You can take it into tax reform. It's hard to deal with right now. And into a lot of other areas.

But just for purposes of discussion of whether you should be in the long-term care business, what kind of service should you deliver and what's your competition going to look like, I would argue that as we move to greater consumer financing and we move away from institutional financing, we will start paying for outcomes rather than paying for specifications.

Rather than specifying we want this, this, and this in terms of the way [inaudible] looks and the way it [inaudible] and all that sort of thing, we are going to say, "We want outcomes. We will pay for outcomes, we will pay for satisfaction. We will pay for longevity. We will pay

for, you know [inaudible] sort of thing. We are not going to tell you how to get there. We are going to pay you for the outcome."

And again there is precedent for that. We don't tell people in the hospital, you know, how many CAT scanners they ought to have and how many of this they ought to have or how many of that they ought to have. But to a degree, the medical malpractice system beats them over the head if they don't have some of that. But I think we're going to move away from that as well. We will pay for outcomes.

And so I think again that is the way it's going. It's going to -- it will go that way in everything, including education. I mean, the concept of the public schools will be -- we'll have public education, but I don't think we'll have public schools by the time my grandchildren are going into the U.S. school system.

I think the school system in this country will be private in the sense that they will be honed institutions operating on behalf of a government called a school district, but they will be selling services to parents who are poor [inaudible] whatever. It won't make any difference because following the course of where we're headed in acute care, you could see that the voucher concepts, the competitive medical plan concepts, all of that sort of thing are built on a private market that operates with a broker

called a health plan, and the broker does the buying of the goods and services on behalf of the consumer and competes with other brokers to get the business of those consumers. And if they don't buy the right facilities and they don't buy the right providers, then people are going to quit buying their health plans. That's how simple it is.

People will buy on the basis of price initially, but in the end they will be buying on the basis of satisfaction. And that same theory where everybody buys a health plan whether they're poor or they're employed or they're retired, they buy the same set of health plans. That same thing is going to apply in education. There is no reason why people can't be good consumers of education. They may even be better consumers of education if they weren't forced to go to the little red box that happened to be within their so-called neighborhood. If they were enabled to have some choice and that choice came to the box rather than the kid having to go to the box and get whatever they [inaudible].

Already that operates on the college level, and I think it will operate at other levels as well.

On the long-term care, they're extending this out, obviously, to the long-term care where you're moving into a variety, a greater variety of social services, whether it's chronically ill, the Jake Javitses [inaudible]

in effect spending health care dollars with basic social services or it's the social service combination with shelter and nutrition and companionship and all that sort of thing. That is a big component of long-term care.

The problem that we have is that we don't have a private health plan marketplace out there. We have private deliverers, like you are, but we don't have private insurance -- or we used to call it insurance, we'll call it health plan or something like that.

Why don't we have it? Because government has the market all screwed up. The government pays so much to proprietaries and so much to the nonprofits, and then every State is a little different, and you know, you've got State legislatures saying you can't build any more nursing home beds, you've got the [inaudible] controversy, you've got all this crap going on out there. Who would want to go into the insurance business, you know, to do that? And yet we should.

We are putting our emphasis now in infant security in this country. We are putting our emphasis on retirement, the IRAs, POs, 401(k)s, pensions, reform of social security. I mean, all the emphasis is going to be on protecting people in financial protection in retirement.

At some point we will start cutting back on that because my generation has got too much. And it's got a lot

more than it needs by way of subsidized retirement. And so on behalf of my children, we are going to start cutting into my retirement and so forth.

But while we are doing that, we will, hopefully, with the help of people like you, we will be creating -- we probably won't call it insurance -- but it will be sort of the planned retirement programs which are already out on the market [inaudible] various forms. But ways to use your income security or savings and so forth to buy the kinds of social services that people need, including some of the nursing home-based services.

So somewhere -- and I don't know where this all comes out -- but somewhere between the health plan for acute care with the nursing home for rehab and all that sort of thing, and the nursing home as [inaudible] nursing home in its larger context. It's really a shelter. I mean, like a hospital is a hotel with a specialized set of services, and so is the nursing home, a home or a hotel or something in between. It's a shelter other than your own place.

But there is nothing wrong with selling somebody a piece of shelter if you want to. I mean, the so-called Rembrandt and the rest of these guys [inaudible] give me your assets and I'll give you a transition from a condo to an apartment to a [inaudible] to an ICF or something like that. I mean, they are all -- they're selling you a piece

of the rock so that you can hang onto until you get carried away and so forth.

So there is lots of creative ways in which we can all think about these things, whether it's for disabled people or whether it's for retirement. The pressure on us now on ICMFR for the mentally retarded [inaudible] waste a lot of resources and sort of categorizing people. The way you get into an ICMFR is to have this condition. Once you're in there, we want to put you in a little home or a big home. That's not the way people would choose to care for their retarded children. And yet because we don't -- we haven't [inaudible] people's choices with some kind of an insurance protection that would make those choices for them, they're stuck with government deciding, you know, here are the homes for the retarded. And government always was in that business with big warehouses, and now we have downscaled that to community-based services. The next system is to just transition that into the private marketplace which you guys can do, that kind of a business.

And you know that there are people who, when they are blessed with retarded children, also have the insurance protection to provide a set of services for them.

But until we, in the larger sense and in the specific sense, are to get our act together in terms of how we're going to pay or what role we're going to play in

paying for some of these long-term care services, it's very hard for the private insurance market to develop.

Well, I really shouldn't [inaudible] much more than that [inaudible].

QUESTION: Senator, what do you see -- you know, it seems to me that the people that are offering insurance programs currently for nursing home care, long-term care, are basically selling that to those people who in fact probably can provide for themselves out of their private funds, and they are not attacking that segment of the population which your voucher system speaks to.

SENATOR DURENBERGER: Right.

QUESTION: Which is they are not attacking the segment of the population that in fact is going to be dependent on the government for support when they get to be requiring nursing home care.

SENATOR DURENBERGER: I think they are just like the Medicare supplemental: they're attacking my parents, who don't need to buy catastrophic or they don't need to buy insurance to cover their cost sharing. They would be much better off if they just paid their bills when they incurred them rather than being ripped off by the supplementals.

But unfortunately, you know, when you haven't got something else, the insurance market is going to go after whatever it can -- whatever it can grab.

So I think that what is part of the problem here is that the insurance industry is so bad. I say this to them, so I don't mind saying it to you. I mean, they just don't think creatively. And the Health Insurance Association of America is just Neanderthalish. I mean, it's just terrible. And I say that because [inaudible] angry with them.

[Laughter.]

SENATOR DURENBERGER: It is the truth. There isn't enough gambling and creativity and so forth there to -- they should be pressing against us when we're doing tax reform, for example. You know, they came to us on tax reform. You're missing something here. You know, there are things, there are ways that you ought to structure savings and investment portfolios or whatever you want to call them so that people have some tax-based flexibility and that can have an insurance policy written against it or something like that.

And I don't understand [inaudible], but it strikes me that what I have seen of good ideas, they come from people who do creative planning for the utilization of assets. Or maybe it isn't an insurance company that does it, but the insurance company sort of always has that in case everything falls through, you've got this by way of backup.

But right now, though, they're not providing the leadership. But then neither are we, you know, [inaudible]. We are doing tax reform without any good sense of [inaudible]. People are saying don't cap 401(k)s or don't have IRA offsets. They're not saying, you know, corporate America wants to see not just a 35 percent tax rate on corporate rate, we want to see you not taxing savings or something like that. We're not getting any ideas. Everybody is reacting to Treasury I, II, or [inaudible] and nobody is giving us any ideas about if we're going to do tax reform, what we ought to do.

QUESTION: Well, I think our point on the tax thing has been one that is coming out and everybody [inaudible] quickly under the heading of reform. And I know that a number of companies that I am associated with have sort of taken the position, well, you know, we've got to go at this with a rifle and we've got to see whether there is something in there that is good for us and whether there is something that is bad for us and put a patch on the patch on the patch and, you know, deal with it that way.

And then, you're right, there is very little sitting back in a constructive sense [inaudible] many businesses feel that they would be very instrumental at this point in time.

SENATOR DURENBERGER: Individually?

QUESTION: With the House out. And we can't get -- you know, people say, "Well, why doesn't business get its act together?" Well, you know, I think basically business has no act. We are individuals running individual businesses, and really we want to see whatever we can get out of it that's good for us.

So even as prestigious a group as the Business Roundtable, representing all the largest companies, has no preponderance of view in favor of any of the tax issues on the one side versus the other, but not a unanimous view, by any means.

And when Packwood came out recently with his modification of it, a number of those who in fact went right along behind jumped ship.

SENATOR DURENBERGER: That's right. Because all Bob did is fragment this thing even more. Everybody got out their scopes to put on their rifle then.

[Laughter.]

SENATOR DURENBERGER: [Inaudible] took care of oil and they took care of timber and [inaudible] gave away the IDBs.

[Laughter.]

SENATOR DURENBERGER: But, you know, Bob could be kind of known to do that.

[Laughter.]

QUESTION: Well [inaudible] temporize because this is the major part of our business is [inaudible].

You know, the point may be on the tax system and it may be off the health care.

SENATOR DURENBERGER: [Inaudible.] They're all related.

QUESTION: But the same thing, that we have come to this rifling thing, and listening this last weekend to a number of companies who are all members of the Business Roundtable and listening to their chairman talk [inaudible] speak [inaudible].

It almost seemed like the whole table was out of order and everybody was saying, "Look, there's only one thing to do: Grab all you can grab, and run and hide and hope they don't find your little niche over here."

[Laughter.]

QUESTION: And I thought, Jesus, wait a minute, you know.

SENATOR DURENBERGER: Yes.

QUESTION: This is a major issue that has to do with the next 20 years in the United States and this is a hell of a way to be going.

So it seems that way. And I came to the conclusion, rightly or wrongly -- I would appreciate your view of it -- that the whole issue of reform is now gone,

the issue is becoming or seems to be moving to one of revenue raising without calling it that, and it has become so complex and so compartmentalized and so rifled that it will fall of its own weight, and somebody will say we've got to start all over again and we've got to do something completely different.

Is that way out?

SENATOR DURENBERGER: No. The Treasury I, even though everybody went and got their rifles in the beginning, they put them away after they found out that, you know, that if everybody was going to get treated this way, maybe they weren't so bad off, you know. But Treasury I was as close as you could get to flat rate taxes for major base-broadening that affected everyone, not equally but affected everybody.

Since then we have disintegrated the notion of broad-based tax reform by protecting special interests in the name of some national policy to preserve oil and gas or timber or God knows what, and at that point the only reform that was left was the 35, the three-tiered individual rate and a 35 percent corporate rate. So that is the only reform that is left.

The question now is where do you get the money to pay for it. And I have always believed you couldn't get it out of the base, not in one fell swoop, that we should be

paying to get us up. We should broaden the base, but we probably ought to collect the money someplace else, through a consumption tax or something to pay for that. But you wouldn't get that much. You go from 50 to 35 or 46 to 35 on a base-broadening on the current America, which is really two Americas at least. I mean, there is half of this country that is going, going, going, but the other half is struggling with the reindustrialization trend and all that sort of thing.

So, no, we, as the challenge tomorrow, when we get to starting our [inaudible] is going to be -- is going to be do we get the money for the rates out of the base or are we going to argue that excise, you know, removing the deductibility for State [inaudible] taxes or removing deductibility of excise taxes is based on -- I am going to say it is not base-broadening, because it is all inequitable. It is inequitable as between States, it is inequitable as between industries, it is inequitable as between businesses within an industry, it is inequitable as between country, businesses that operate in rural areas [inaudible] that operate in the cities.

There is a lot of inequities [inaudible] to eliminating taxes paid as the base [inaudible]. But they will sit there and we'll argue that is that base-broadening or is it not? And we will lose sight of, you know, some

important national purposes by doing that.

No, you're right, and clearly it's too bad, but I think it [inaudible] but Reagan believes from his General Electric days that the lower the rate the more the revenue. And I don't know what we can do about that. And we have to do base-broadening anyhow, because that's where you've [inaudible] because we all know we should do base-broadening, we all know we're going to get rid of investment tax credits sooner or later. Now the question is how you get it done.

QUESTION: Are you impressed with the fact that [inaudible] twice before the investment tax credit [inaudible] both times, related or unrelated, we've had a dip and then we've had to reinstall it [inaudible]?

SENATOR DURENBERGER: Yes. Yes. I am impressed by the fact, for all the reasons that I stated in my opening remarks here about the fact that we're in a new era and all that sort of thing, where we really are going to look carefully at subsidies, where we put our subsidy money.

We didn't do that in the '60s and '70s. We brought it back because it related to the cost of [inaudible] capital.

QUESTION: Yes.

SENATOR DURENBERGER: A variety of industries [inaudible]. I don't think that's where we're headed now.

I think we're in a free market.

QUESTION: The other aspect, though, of the new era is that we are clearly in the global competition [inaudible] and we feel that in a number of our businesses. And in some of the boards that I am on [inaudible] most notably the automobile business, is the [inaudible] and we are dealing away major industries because we are not at subsidized [inaudible] as bad as that term may be, and we are not as subsidized as the competitors, and they view their business in a much more integrated part of their society than [inaudible] being the classic case of, you know, see it as a means of producing hard dollars.

Why hard dollars? Well, that's the only way you can buy oil. They don't have any oil. They don't have many natural raw materials. So they need the hard dollars to buy those things, so they need an exporting automobile industry to develop the hard dollars.

So then the automobile industry becomes something that gets what it needs to compete in the world. Very material subsidy for exporting automobiles. And that is the real world. Those are the guys who are trying to take our markets.

And I think we deal at times with the issue of taxes and the issue of how we raise revenue and how we deal with our subsidies on a national basis when the arena really

is a global basis. And all that does is then add two powers, I guess, to the degree of complexity of the problem. But it is nonetheless there, and the extent to which we remove an investment tax credit or whatever form the subsidy takes from industries that are struggling to survive in the global competition and not really doing very well, American industries today, I think we ought to at least take the responsibility for the probable consequence of that.

And then I wonder, you know, can we exist without a viable, growing automobile industry? Can we exist without a viable, growing [inaudible]?

SENATOR DURENBERGER: That's the issue of [inaudible].

QUESTION: You know, England does, and they don't have much of that. I hope we don't take the road of trying to emulate them because I think they're going down the tubes and would have been down the tube now had we not found offshore oil.

Those are the dilemmas that I see. And I guess in a matter of principle, I guess I would say that when we deal with -- I have no problem with dealing with a subsidy as a subsidy, giving it to the consumer and banking on their having the intelligence to use it effectively. And from our point of view that works well because we would like to compete for the consumer dollar. But in the broad sense,

whether they do that within the context of domestic or global I think deserves a [inaudible].

SENATOR DURENBERGER: And I would argue that we do, but I know that I am swimming upstream in the near term. But that's where it gets back to a national security policy [inaudible]. In other words, if you adopted my theory literally of this interdependent world, you would ask the American consumer what they want by way of quality and what they're willing to pay for it. And if they got it from the Japanese or the Koreans or [inaudible] everybody [inaudible].

The easy answer is in the '60s and '70s we were just spending money on good ideas and we found good ideas all over the country, but not necessarily in Washington, D.C. So [inaudible] was kind enough to point out [inaudible] people have good ideas. I found [inaudible] people are always very anxious to tell you where to go or what to do.

[Laughter.]

SENATOR DURENBERGER: And they're just full of them. Even Paul [inaudible] started out as [inaudible] for profit policymaking business [inaudible] for some reason or other.

But because we are what we are in this country, de Tocqueville spotted us as a little bit different from at

least the French, perhaps from other people. We are great at associating, we are great at networking. Now we call it networking; we didn't do that in 1830, we associated. But the whole -- the emphasis of course in this country is when you find a problem and a person with a solution [inaudible] peanut butter or something. You've got to keep moving it around.

And what happened in this country in the post-world war period was we got this engine of redevelopment or development going in America to the emphasis on consumption and emphasis on spending and the emphasis on recycling product and so forth. We found that through using inflation and expectations and having without paying for it, all that sort of thing, in this country we're able to have a whale of a lot. We could have inventions, we could have innovation and we could have new cures and we could have remedies for everything that came along.

And so in that atmosphere the place where new ideas actually came about was [inaudible] local level, community level, did not have the capacity to finance them on a community basis. And so they take them to the State level, and the States didn't have the capacity to finance them because States were largely rural-dominated legislatures, part-time legislatures.

Even in our progressive State like Minnesota, the

legislature only met [inaudible] once every two years.

So we didn't have the capacity to deal with public responses to new remedies for various problems. So politicians took these solutions that were created in places like Minnesota to Washington, D.C., where inflation was taking people's income in the form of taxes. And the two met up in Washington, D.C.

And a great idea would come out from Sister Kenny or American Rehab or something like that, and go trotting off to Hubert Humphrey's [inaudible] to Washington, D.C., where [inaudible] 51 percent of the Senate and 51 percent of the House who would have similar problems in their own States, and he had a solution.

He converted it into a categorical grant program, put enough money against it to at least get demonstrations out there or [inaudible] out there for people to chew away on. And over a period of 15-20 years we developed what they called cooperatives or categorical federalism. And [inaudible] solution became national programs to solve problems.

Now, obviously, in doing that, he did a lot of good. We found that we developed a lot of capacity and a lot of people to resolve a whole lot of problems. And we kept [inaudible] remedy and so forth moving quite rapidly across this country.

But in the mid-'70s we got to the point where people started complaining about the fact that all of this good that we were doing was starting to cost too much. Taxes were too high. The Federal Government and other governments seemed to be spending too much. Cost of health insurance was rising then at ten percent a year [inaudible] 20 percent a year or 30 percent a year, something like that. People started, you know, getting a little bit tight with their money.

In California, in 1976 or '77, we had Proposition 13 [inaudible] succeeded by Proposition 2-1/2 in Massachusetts in 1976. We had a governor from [inaudible] President of the United States on a platform that he would balance the federal budget by getting rid of all the bureaucrats in Washington, by getting rid of the Washington that told everybody else how to do things.

There is a flip side of what Hubert and everybody else was doing, taking all these ideas to Washington and bringing them back in the form of money and solutions. Jimmy Carter [inaudible] too many bureaucrats out there, too much government, too much spending, costs too much.

So the country threw out Gerald Ford because he was one of those guys that took ideas to Washington, converted it into money and took solutions [inaudible] and they put Jimmy Carter in charge [inaudible] took Jimmy

Carter out and put a 70-year-old movie actor in charge.

[Laughter.]

SENATOR DURENBERGER: And if their objective was to start living within our means and balancing the budget, things like that, what is the proof that the Federal Government is starting to live within its means?

[Laughter.]

SENATOR DURENBERGER: We went from a $400 billion deficit when Carter took office, to an $800 billion deficit or national debt when Reagan took office, now it's $2.1 trillion, headed for $3 trillion.

So how in the world are we going to deal with this appetite that Americans have for doing good for each other within the sort of new-found American ethic which is, "I don't want to buy anything and I don't want to pay for anything that I didn't order," that kind of a notion.

Well, in health care we have an opportunity that we don't have in some other areas to deal with that particular issue. In my capacity as chairman of the Senate Select Committee on Intelligence I am bringing some of these same solutions to bear there. I have written a book, for example, called Neither Madman nor Messiah," which helps to bring me here to you today, and which is a policy of national security, which in effect takes the national security defense policy of this country, turns it on its

head and says, "Why do we do this? Why do we do that? How much of this do we need, how much of that?"

It sort of takes defense policy way from the Army, Navy, and Air Force and Marines and puts it in the hands of the citizens of the country. And it is, in effect, a "consumer choice of national security" approach, much as I have chosen to follow in the gulf policy area as well.

The thesis of reform in health care is responsibility. That one-word reason why we are following consumer choice in the financing of health care, the word is: responsibility. It is illustrated as follows -- I am just kidding [inaudible].

In my last visit to Puerto Rico, I had the opportunity to visit with San Pablo Hospital in Vallemont, which is a suburb of San Juan, and a very bright young administrator at this very nice hospital -- it looks like it's owned by the doctors, very good-looking hospital -- was telling me about their problems with malpractice. To illustrate it he used the example of a 55-year-old woman who had just suddenly died and they just settled her claim, malpractice claim.

But the background was that she came in with a severe cardiac problem into their intensive-care unit, and they noticed while she was there that her husband would come in twice a day with a package of cigarettes. And so she'd

stick her head out of the oxygen tent and puff away like this.

So he became dissatisfied with the care she was getting at that hospital, so they took her to Houston Methodist, where one of the two famous doctors over there -- I think it was DeBakey or maybe it was Cooley; I don't want to blame either one of them -- operated on her, did a couple of bypasses. And she died.

So the husband sued both Methodist and San Pablo, and they both ended up settling. But the point of it was the administrator asked me this rhetorical question, which was: "Why do I have to pay for self-inflicted injury? Why do we as a society have to pay for self-inflicted injury?"

[Laughter.]

SENATOR DURENBERGER: I used to sit there with my pipe all the time, but I finally gave it up. But I am not here to make a health lecture.

[Laughter.]

SENATOR DURENBERGER: But the point is self-inflicted injury [inaudible] responsibility. And that is really the point of the whole issue of consumer choice in health care. That's what's behind prospective payments and vouchers and competitive medical plans and things like that. And I wanted to lay that out very briefly and then let you talk to me about why it doesn't apply or why it would apply

if it were done differently [inaudible] rehabilitation area.

But I need to lay this framework for where we're headed so you can help us make appropriate policy. So you can see that we're not out to regulate the finance, the health care financing industry. We are out to restore responsibility to you and me in the area of our health and the health of the people around us.

So how do we restore that responsibility? Simply by making people recognize the consequences and the costs of the consequences of their actions. If every time you went to buy your accident or health or life insurance or your whatever it is, your pension that your companies or whatever, you saw something other than age and sex as a factor in your premiums, like life style, you might say, "Well, how about that," you know. Life style does make a difference and you can put dollars next to it.

If that were the way you were raised, you would find some way to adjust your life style to your [inaudible] or your [inaudible] of that life style.

But we, my generation, some of whom are in this room, a very few people here who are as old as I, but my generation has never had that experience. My generation was born in the Depression, of parents who swore that we would never have to live through a Depression. So they deliberately created having without paying for it. They

deliberately created this environment in which I never had to suffer the consequences of my actions.

I was raised to believe that it is much easier to get sick than it is to stay healthy. I was raised to believe that you wanted time off from work, go to the hospital. And if you went there, you know, people would send you flowers. Your boss, your employer would pay, they would send you flowers and cards and come and visit you.

If you stayed at work, you had to work for your money and people complained about what you did, and nobody ever said a nice word. Nobody certainly ever sent you a card saying thank you for staying well or healthy or whatever.

So if I am raised on that, then is it any wonder that I end up paying $500 or $600 a day for a hospital room and, you know [inaudible] of thing. I mean, price is no object. I have a right to get sick. And when I am sick, I have a right to the best care, whatever that means.

So where were the incentives in the provider system in my time to do things more efficiently? None. [Inaudible] I don't know how the dentists ever got in the fluoride business or the brush your teeth every six months or, you know, working themselves out of business. Dummies.

[Laughter.]

SENATOR DURENBERGER: Why did they bother? You

know, they are. I mean, they're -- a lot of dentists are in trouble now because they, even though all the incentives work the other way, they bucked the tide. But then they had to use legislatures to force fluoride on us and they had to use -- but they were able to get through to insurance companies and things like that [inaudible] six-month examination.

But only in dentistry did you clearly see in a whole profession, you know, you see this kind of emphasis and actually see it work. Everywhere else we have had to rely on major changes in the overall financing in order to provide the doctors and the medical professional, rehabilitation experts and therapists, everybody else with the opportunity to do better for less, to give greater value for a smaller expenditure of time, money, and effort. But we are moving in the direction of enabling you to become the supplier of the most needed product at the best price by prospectively pricing the sick care that we provide.

How we get there, nobody knows exactly how we're going to get there. You know how we start. We start by taking Medicare, which is the largest of the insurance programs this country [inaudible] covers 30-31 million people, something like that, and using Medicare as the engine we changed the reimbursement system for hospitals. We started to change the reimbursement system for hospitals.

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It was always our intention, as you know, to continue this prospective pricing arrangement so it included all providers. In the beginning I for one thought that you could take the hospital DRGs, then just expand them. You could fold in Smith and the rehab and, you know, all that, and the docs and everybody else, fold them into one price. Give the doctors, give the doctors money and let him decide whether the person went into the hospital or went to a rehab unit or stayed at home and got home health or whatever, and let the physician or some other source of [inaudible] of health care decide where to use that money.

Now [inaudible] I am less confident, substantially less confident, let 's say, that you can have one price for 467 or 468 or some other number of procedures. You may be able to do that for hospitals, say, but you probably need some other kind of a -- we clearly need another prospective measure for physicians, and we are moving in the direction of relative value scales, which the physicians have recommended to us many years ago but the Federal Trade Commission turned down as anticompetitive.

Now we're backing [inaudible] as a sensible way to do it, which only proves again that had we put health care in this country in the hands of professionals a long time ago instead of putting it in the hands of those of us [inaudible] we all might have been much better off.

So with physicians, we are going to a different kind of a prospective pricing program based on relative value.

In the other areas, we are -- all I can say to you is that we're going to try to prospectively price our purchases. But how to do it, it is a little difficult right now for us to determine.

Dr. Bethe mentioned in the introduction that the future of sick care and health care purchase in America is the private health plan, now called competitive medical plans in this legislation which she referred to and that I introduced on behalf of the administration. It really is not my work of Medicare restructuring. I have a whole other thing that I am working on in Medicare restructuring. This is the administration view, 1985 or whenever it is [inaudible] 1985.

They call it health benefit organizations, but however you look at it, the future is health plan which incorporates a wide variety of health-related services from wellness, prevention and diagnostic through the acute care, the rehabilitation, home health, and then eventually into, for the elderly in particular and for the disabled, into a system of long-term care, which is primarily social services.

So that kind of coverage will be bought from a

private health plan in the private marketplace and will be paid for, in part by the Medicare trust fund at the premium level, in part by employers, and in the premium level where employers want, have promised or made a commitment to [inaudible] and in part by the individual involved so that not everybody is buying the same plan. Everybody can buy as much as they want, and they might pay different amounts for different parts of this health plan.

It is also conceivable that we will see three different health plans on the market. You might find one for health promotion and disease prevention, and if you care you might find another one for social -- what we call the social HMO or the lapover between the social services and the health care. You might find a third one for other, more refined forms of long-term care which include shelter components and things like that. I am not sure. Nobody is dictating how this market works. We are jus trying to encourage a market of private health plans to get us out of the DRG business.

And that is sort of the bottom line of all of this, that having started out to use Medicare, we show the value of prospective pricing, we don't want to stay in the prospective pricing business too long because we aren't sensitive to the marketplace.

Back 30 years ago, when the Hubert Humphreys and

everybody else came down here to do good, they had to do good like peanut butter, as I said. No, they found a problem and they spread it through 50 States. They even spread it to States that didn't have that problem because that's the way they had to do it. And of course, people found problems even in States that didn't have them so they could have access to these programs. And that's where the wasted resources came.

So with this regulatory system we are currently employing, problems are not approached the same all over, but they can be approached differently and at different rates of cost. And so it is inappropriate for us to stay in the DRG business for any longer than we have to. So our objective is to move out of it and leave the financing of sick care in this country to private health plans, to make their own arrangements in the marketplaces in which they operate for the payment of a variety of services.

Otherwise we have run into, you know, sort of the unfair problem. We run into the swing bed at the hospital versus the nursing home problem, and we run into the hospital-based rehabilitation versus the freestanding rehabilitation, and we've got all these problems that a regulatory approach does not handle very well. It really doesn't handle very well. And obviously we shouldn't be dictating the mode of service delivered.

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The value that a consumer puts on a product, the value that a professional puts on the quality of care that is delivered in a certain area, those are the kinds of things that ought to dictate the setting.

Price can dictate the setting as well. That is part of the value. But if we try to dictate the setting as we presently are, and insurance companies do, you know, when you can only get reimbursed if you get your rehabilitation here rather than there.

On chemical dependency treatment, we pay for it in a hospital but we don't pay for it in some other settings. That's ridiculous. That is a ridiculous way for us to approach the delivery of care.

We used to do some of that because we were trying to force things out of hospitals. Well, for example, on ambulatory surgery, we set up one rate for ambulatory surgery center just to force the business away from the hospital into the ambulatory surgery center. Well, that was just so we could find out whether the marketplace in ambulatory surgery worked, and we found out that it didn't. Now we should be pulling back with one rate. Let the marketplace decide where you go for those services.

So I think probably, for the sake of time, having given you that kind of a background, I should shut up. In terms of predicting where we're going this year, it is

impossible to do that with any accuracy. You know we're sitting on a freeze, which is ridiculous. You know my position on that, which is a freeze will kill reform quicker than anything else.

But I will tell you that I got beat on the floor last year by Gramm-Rudman and Packwood and others who think that Medicare is simply a system of payments for doctors and hospitals and rehabilitation centers and so forth. They don't think about it in terms of health care for people. That becomes your responsibility to try to get that message across to a lot of the people in this -- in this Congress.

This year, hopefully, we will expand the dollars that are going to the system both in the pass-throughs, like the rehabilitation facilities, and also to the hospitals. I don't know whether they'll be able to make it. Nobody knows for sure where we're headed in terms of making our $144 billion target.

I just know from experience that Medicare, because it has saved over $30 billion, that the trust fund of the taxpayers of this country is now an easy mark for budget cuts. Because we have done good, because we have shown people how to change the system for the better, because we are demonstrating that people who care care as much about efficiency and affordability as they care about the quality of the [inaudible] we are being penalized, all

of us who working in the policy reform area.

It ain't fair. But -- and hopefully, it won't last too long, if people like you take strong positions in [inaudible] reform and against using budget-cutting against that, against that kind of reform.

I think the good news, though, is that the news of change and reform and value and those sort of things is getting out. I think there are more people all the time that are coming to Washington, holding conferences here and talking about the values of the changes taking place in the health care area so that I think as we move this year towards holding capital in the hospitals next year or this year, doing physician reimbursement, that we will be able to do the changes that are needed, needed in the reimbursement of health care.

But don't worry that many of us here are trying to tell you how to do your business. It is really up to you to tell us how best to finance the access of people into the kinds of businesses that you are [inaudible] keeping in mind what I said about our objective: individual responsibility. Individual responsibility. Value for what you receive. And value in combination of the quality of the care that you receive, the setting in which you receive it, and the dollar that you have to pay for it.

And then the third, of course, is just the long-

range progress towards finding better ways always [inaudible] nobody has ever perceived this reform as stopping America in its tracks. We have to keep finding better ways to do things all of the time, whether it's in drugs or rehabilitation therapy or whatever it is. We can't put a crimp in the system that says just because it "costs too much" we can't afford to go out and find better ways to do things.

We always have to keep in mind that it costs money to make money and that we need the ability to make investments in the future care, new kinds of care that [inaudible] we can't ever stop the system in its tracks and say, "I'm sorry, all we can afford is what we're doing today." Baloney. We do so much inefficiently with the health care dollar in this country, there is more than enough for creativity and innovation and ingenuity and better care in America's [inaudible].

So thank you for inviting me to be part of this, and I would be pleased to respond, to the extent that I am able, to respond to any questions [inaudible].

Who wants to be the first? Yes?

QUESTION: Senator, we see the movement to a voucher system [inaudible] consumer [inaudible] for purchasing health care. Are we going to see the disappearance of peer review or PROs? In other words, if

we're going to make a "consumer choice" purely, will the industry drive the quality reviews [inaudible]?

SENATOR DURENBERGER: All right. The question, as I understand it, relates to the future of peer review in all of what we're doing.

Let me say, as the champion of peer review here, that I think that peer review we will always have with us in a professional sense. I expect we will not have it with us in a legislative sense. Peer review has been terribly important, thank you, to work this change so that we have medical professionals guiding the change from the cost-based reimbursement system to the prospective reimbursement system.

When you have preadmission screening, when you have all the rest of these new things happening, you better have some medical professionals around to make sure that it's done sensitively.

Now I realize in some parts of the country it's done better than others. But that was is the -- that is the theory of peer review now. Utilization, help us with utilization. Help us with preadmission screening. Help us with quality. Help us with physician practice pattern changes. [Inaudible.] The overutilization of resources is coming to an end.

But all that means we in the larger sense need to

have the helping hand of peer review in that process. But once that process has been accomplished and a lot of these new systems are in place, then I think the nature of peer review changes and it gets back to where it has always been. There has been a sort of an institutional peer review. It's a built-in quality mechanism in each institution that [inaudible]. If we don't keep quality up here, number one, we aren't going to get the business [inaudible] or whatever.

Hospitals have always done this. Medical clinics always do this. Any group of medical professionals always has a way to maintain the standards of quality care [inaudible] I suspect that that is where we will end up. In addition to that, of course, you have at the State level, you will always have licensing and [inaudible] that.

Does that address your question?

QUESTION: Thank you.

SENATOR DURENBERGER: The next question in the back of the room?

QUESTION: It seems to me that if you want to make an impact on the health care, on the Medicare trust fund, that you would consider long-range a means test for Medicare [inaudible]. Have you seen any movement on that [inaudible] reform movement?

SENATOR DURENBERGER: Well, where are you from?

QUESTION: California.

SENATOR DURENBERGER: Okay. You've got two Senators. Get them to endorse my bill. I can't think of the name of it but --

[Laughter.]

SENATOR DURENBERGER: -- I put in a bill that means tests Medicare in 1982, and I [inaudible] I got no scars from old folks or anything like that. And I will tell you how I did it. I combined Part A and B, put a premium on the combination of that, charged about 15 percent of the program costs to everybody so that the poor could not say that they couldn't afford Medicare. Then I got back the difference between 15 percent of program costs and 95 percent of the program costs off one percent of adjusted gross income on all the elderly and disabled [inaudible].

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

10/1/86

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SENATOR DURENBERGER: And I'm still Chairman of this Committee. The sun still rises, and politics goes on as usual. We have been spending a fair amount of time raising money for our colleagues, since we think there's a value in having a Republican majority. In this group, I'd probably say a two-party system. I don't know what your politics are.

But, this is the end of even numbered years. And the world seems to be full of politics, and your lives are full of television commercials. And I just want to say I'm not here to solicit anything. I'm here to share a few thoughts with you this morning. And to try to shed a little light as Jim did in his remarks about the future.

When I asked some of my staff people what I could entitle this speech, they said that I probably ought to get down and be real honest and say the future of renewable fuels is no longer (Inaudible), it's got to be something else. When I walked in here and listened to the last five or six minutes of Jim McClure's speech, I began to get the feeling that maybe that was the appropriate sort of title for this little set of remarks of mine.

And so we might as well just start off right at the beginning by saying that, while I've been on the Finance

Committee, and I've had an opportunity to carry a lot of alcohol for this organization in various forms, the honest way to approach the future is by saying that some things are happening in this country that dictate that we don't put all of our eggs in one particular basket. We start distributing them around a little bit.

And from the view of the Intelligence Committee, today I would like to share some of that future with you.

Gary was very generous in his introduction. I have loved every minute of the eight years that I've been in the United States Senate. I replaced Hubert Humphrey coming out of Minnesota. That leads a lot of people to believe that I'm a Democrat. I'm not. We elected two Republican senators in Minnesota eight years ago and both of us are still there. It's sort of an incredible kind of situation, but it's happening all over this country.

So now I'm the first Chairman of the Senate Committee from Minnesota since 1931, despite the Humphreys and all that sort of vote.

Well, what does that mean? Well, it doesn't say anything special about me. But it says a whole lot about what's going on in this place up on the Hill in terms of the kinds of people that are coming into this process. And also it turns the kinds of issues that we are being asked to address.

I usually start a remark like this with so many unused to me being Chairman of the Intelligence Committee by asking how many people know what an oxymoron is. That's two words that are mutually inconsistent. Like Senate Intelligence.

(Laughter)

SENATOR DURENBERGER: And with the right kind of audience, I say you seem to be a member of the Senate Ethics Committee.

(Laughter)

SENATOR DURENBERGER: That's a real oxymoron.

But to go from there to where we are today and where we are going in the future, let me just pick up where Jim McClure left off. I want to talk a little bit about Saudi Arabia or whatever. I want to talk a little bit about agriculture. I want to talk a little bit about the environment. I want to talk about all the other issues, besides tax policies, that are involved in one way or another in renewable fuels. But let me just be honest -- Jim has a hard time doing this because he is, he may be a more visible and more conservative Republican than I am. But the reality is, that from the day that the two of us sat in the President's Office in 1981 or '82, I think it was, with the Secretary of Energy, whose degree was really in dentistry -- it had nothing to do with energy -- I knew, he

knew we were in trouble.

(Laughter)

SENATOR DURENBERGER: No question about it. Well, that was a one hour experience in which we argued for a national energy policy premised on some combination of scroll and conservation and tax credits and on some kind of underpinning under a national energy policy that would be translated into legislation. But could be counted on from year to year. People made investments.

And to be honest with you, because it was late in the afternoon that we had the meeting, the President dozed off a couple of times.

(Laughter)

SENATOR DURENBERGER: And the Secretary of energy was there to say, we have an energy policy. It is the free market. And that's what it has been ever since that meeting. It is the so-called free market. And as Jim McClure just told you, one of the major problems with the free market is that a free United States attitude towards the market is wonderful as long as somebody else's disposition to cartel lobbies a large part of the energy future of the world. And if you're going to translate free into absolutely free, which means we don't pay attention to what's going on around us, that we will permit cartelization, and that we won't try to exercise any

influence over cartelization, well, then, yes, you have an energy policy. But you also have some disastrous consequences for economic policy and a whole lot of other things.

So, we have two more years to be realistic about it. We have two more years of a market-oriented energy policy, if you want to call it an energy policy, of the United States of America. So, that's the bad news. And that's the sort of reality. You just meet -- well, you already know the reality, I don't have to tell you that.

But that is the reality as perceived from their view and from my view.

Now, what are we going to do? What are we going to do about that, how are we going to deal with it? What are our hopes and our expectations?

Well, for one thing we try to hang on to as much as we have as we possibly can. And when we went through the tax bill in the Senate Finance Committee, we were faced with another example of we want the marketplace to work.

We looked across the income tax in America when the Republicans took over in 1981 and it looked like a mountain range. You and I were up here at the top of the mountain paying in the high brackets, and our neighbors were down in the valley, not paying anything at all. So, we said we're going to do something about that. 1981, we cut off

the tops of the mountain. We brought marginal rates from seventy to fifty percent, we reduced all the rates by twenty-five percent, we did accelerated appreciation, and a bunch of things like that. We upped the tax credits on ethyl and so forth.

So we did a lot of wonderful things for a lot of people. And but the main thing is for the public generally, in fact from here, we brought the rates down by (Inaudible) the tops of the mountain.

But we didn't do anything for the valleys. In fact, we created, we put more people in the valleys, because from then on, that's when Dolley Parton went into farming and a lot of people --

(Laughter)

SENATOR DURENBERGER: -- A lot of people bought barges and railroad cars and things like that that they didn't really need. And, in effect, we bankrupted the railroad industry and the barge industry and a bunch of other people in the process. But we gained a lot of taxpayers who no longer had to pay taxes. So, we sort of widened the valleys, there were more folks in the valleys. And the folks at the top were down a little bit.

But they could still down from up there in the fifty percent bracket and see all those folks in there paying taxes. So the next phase of tax reform was to be,

how do you bring them closer together again?

And the next step is to bring the folks in the valley up a little bit farther. Now what's the best way to get the folks in the valley up is to promise a larger number who are sitting at the top of the mountain that they could come down.

And so Treasury one, Treasury two, Rostenkowski one and two, and the Packwood Finance Committee said that we have a tax reform. It was simply that, the compression of the American taxpayer, bringing the marginal rates down now in five years from seventy percent to twenty-eight percent on individuals, forty-six to thirty-four in corporations, and an alternative minimum tax, which is twenty-two percent, and the elimination of the investment tax credit and length of up to three full (Inaudible), and cutting back on a wide variety of tax expenditures that are in that bill. Filling in the valleys, bringing the people up.

I'm going to suggest to you, whether you like it or not, I like it or not, whatever, that's the future of income tax policy in America. By bringing the marginal rate down from ninety-three percent to seventy percent to sixty from seventy percent down to twenty-eight percent in the '80s, we are moving the income tax in the direction of the black, so-called, black past that a lot of people have been talking about. We are trying to move the income tax to the

position where you need a regulator rather than a motivator of investment decision.

And that is the direction in looking at it in 1986 terms, that is the direction you want income tax policy in this country to go. That means, in effect, that even the six cent credit that we hang on to with all the rest of the things that I'm committed to, like, forever, are going to go. And I can fight my colleagues, I can fight Brazil, I can fight Ray Barnhard and Secretary Dole of Transportation only so long if the American public wants this thing to come together like this. If the American public wants the tax code not to dictate investment decisions or other kinds of decisions, then we can hang on to the tax code only so long as our kick-in gives to the energy business.

And so given that kind of policy direction, the next question is for all of us, do we want an open, absolutely flat income tax, or do we want to pull out of our tax policy certain kinds of policy decision, and use the earning of income and the taxation of that earning as a way to get people to do certain good things, which has always been our philosophy of how do you create tax incentive?

So, there's going to be a period of time when people are going to say, hey, wait just a minute. An absolutely flat income tax doesn't give anybody any messages. Let me give you an example. Most people under

thirty years of age do not believe there will be any Social Security for them. They're paying six thousand dollars a year between employer and employee into a Social Security trust fund that they believe will not be there when they retire in the year 2025, or 2020 or something like that. Because they're smart enough to realize with the demographics and everything else, that we would have to have a payroll tax of about twenty-five or twenty-six percent in order for the Social Security trust fund thirty-five years from now not to be bankrupt. So they have already figured this out. I have yet to find a person under thirty who believes there will be Social Security there, even though they're putting all this money in.

So, what am I going to do about that? Well, lots of people say, hey, reform Social Security. Take some money away from the old folks down there in Florida and all that sort of thing. I say, that's not the way to do it. My parents are down there in Florida, better off than they were at the time when they retired, but they expect that next year some catastrophe's going to fall on them, like the Depression, in which they were mature adults, and so they don't want to touch Social Security.

And, we don't have to touch Social Security. Because we have about fifteen or eighteen years before it runs into trouble. So why reform it today? All you'll do

is accumulate a lot of money in a trust fund so that we can borrow it in order to pay off the deficit.

Now, what should we do? We should take the tax code today and say, if you hurt the money that you earn or take out of your savings account or whatever to spend this year, if you put it into consumption, you pay, say, at the thirty percent rate. But if you save it, you pay at a fifteen percent rate, or something like that. Just a major differential between what we do with earned income. If we say consumption is so much, say if it is so much down there, I swear in ten years you can do all kinds of things to the social security system. You can (Inaudible), you can do all kinds of things, because those people who are out there earning that money will have had ten years of signals from their government saying, saving is good, consumption is at least stupid.

My generation, for thirty years, has been taught to consume. Every signal in my life, and the life of all of you, most of all of you, half of you are of my generation, probably -- right, Larry?

(Laughter)

SENATOR DURENBERGER: Ten percent of the people here are in my generation. All we've done is consume. We've had the free house, you know, nothing down, forever to pay, low interest rates. We pay housing for five thousand

dollars to eighty-six thousand dollars a year. Now our kids can't afford housing.

We've done the same thing with health care. Everything else. All of our adult signals have been consumption.

Now our kids are coming along. If you want to keep those same signals up, they ain't going to make it. If you want to change the signals, the income tax code is a great place to change the signals, because everybody has to earn income.

So, that's an example of how a nation can structure in its income tax not to say buy 401 Ks or 403 Bs and these things happen to you. If you buy IRAs, this will happen to you in that bracket, and that'll --no. No, no, no. Much too complicated. Just a two-tier income tax system that says consumption, consumed income is tax up here, saved income is tax (Inaudible). That's not that hard to come by.

You can do the same thing for health care. Instead of doing the system we have now in health care, where, if you're lucky enough to work for a big company with a big union, you get free health care and you're not taxed on the employer contribution. But if you're a farmer or a small businessman out there someplace, you can hardly afford health insurance, and if you can afford it, you're paying

for it with extra tax dollars. And you get no breaks. Now, what kind of country is that?

The very simple way to solve that is to have everybody report as income the cost of the third party's contribution to the health plan. But then if everybody in America deducts it for the health insurance premium. So that the farmer gets a deduction for how much he pays for his premium. And the guy that works for U.S. Steel or Chrysler gets the deduction for what Chrysler and that person paid. It would be real simple. Then we're all fair across the board. In fact, the farmer gets a bigger break, because the farmer's premiums are going to be larger than a large group.

Well, if we want to do that, if we want people to buy enough insurance to protect themselves in a market, and we want to make it fair to everybody, you can use the income tax code to do it.

So, if we want to think about energy policy in terms of tax policy, we can do it. I'm just saying to you, that in the short term, you're going to have a heck of a hard time getting away from it.

Now, I advocate trying to get other policies out of your nation. For example, Jim's already said and I've already replied, that we need an energy policy. And the rationale for an energy policy today ought to be national

security. Pure and simple. The greatest problem -- two great problems facing America today that relate to energy -- are the Iran-Iraq war, which you never think about, or almost never think about, and Mexico, which you think about if you're from Texas or southern California, or someplace like that. The possible bankruptcy of Mexico, and the possible victory of the Ayatollah Khomeini over Iraq have incredible consequences for U.S. national security and energy policy. I mean, I can see us very shortly back in the lines making (Inaudible), you know, if something of that kind of catastrophe, particularly that Iran-Iraq, occurs.

And let me tell you as Chairman of the Intelligence Committee this is more likely to occur than it is likely not to occur. The Iranians are winning. They're crazy. They're out to get Kuwait, the Arab Emirates, the whole shmeer. They are sending those same Shiites and other fanatics that are undermining east Beirut, are in there right now and they have been for a long time, undermining the (Inaudible).

But why, why does your country permit -- what is it, just in the last -- hell, I should have stuck to my prepared remarks.

(Laughter)

SENATOR DURENBERGER: But why do we permit oil permits in June at thirty-nine percent, if they were twenty-

seven percent a year ago? OPEC share rose from thirty-six up to forty-three. Many experts predict that OPEC will supply over one-half of this country's imports in a little over a year. Why are we letting that happen? Because this is a free market. Because this is a free market.

You know, we can't learn from 1979 and 1973 and all of the other things that have happened in our lifetime. That wasn't so long ago. You know, I was here in 1979 and I feel like I just got here. But it's a reality. Why such short memories? Because of our value system advocates that money. We're still in the consumption mode. We still want to pretend that we don't have problems, we don't have to conserve. We don't have to go to alternative fuels. We don't have to hold down the place. As a people, I think that's fair to say.

But, we desperately need an energy policy. And I would premise it on national security reasons. Jim told you that, if we let this thing go on too far in this country, in terms of the basic fossil fuel in the energy industry, and the thing is destroyed -- which it might likely be, at the rate that we're going -- it'll take three to five years to bring it back. Well, you know the paralysis to a nation of an energy crisis. An economic paralysis as well.

(Applause)

It's too late back to bring a domestic energy

industry. If it takes three to five years, you know how quickly those things can go down.

Is it a manipulated market, as Jim McClure says? You bet it's a manipulated market. It's as obvious as anything to anybody. Well, why don't we manipulate the market? Who are the biggest consumers in the world? Where's the biggest market for all that stuff in the world? Who are the people who are sending singers to Angola when we don't even have an energy policy that would relate to the future of the Angola people? Where are the people that are going around begging to get some more money for Nigeria when Nigeria's got its own well, but we don't know how to use it. Because we haven't cartelized the consumers of this world, in a good sense. Or Mexico. Or Ecuador. Or a lot of other places. Brazil. We're beating up on Brazil all the time. Well, I have to beat up on Brazil because they're setting off all the alcohol fuels in here.

But. Brazil could be a very good trading and security partner to the United States if we ever decided what kind of trade policy we have. The Brazilians, at least, are trying to turn their country around, turn their economy around, get control of inflation, and build some infrastructure inside the country. And, yes, they're using the great bazaar, the United States of America, as a place to help build that. But they have a hundred and thirty

million people. The Taiwanese have, what, six million or something like that, something relatively small. Hong Kong, how many people (Inaudible)?

There is a lot bigger impact on the American market coming out of places like Hong Kong and Taiwan and places like that than there is Brazil. But where is our greatest national security statement in the long run? Is it in the healthy Brazil, a hundred and thirty million people with a standard of living that should be going up, up, up, be a market for American products of one kind or another? Not be dependent upon having to dump their products on our market. Or, is it Hong Kong?

Does anybody talk about these things? Very little. Behind the scenes (Inaudible) of Hong Kong talked to us about it, the Brazilians talked to us about it, and the Argentineans talked to us about it, but the United States has not structured their national security policy or economic policy that can deal with the realities of developing these countries.

Well, my job is to keep their products off my market because their ore competes with my ore, their alcohol competes with my corn, and I can go on and on and on.

So, what happens? You've got 50, you've got 100 senators, with 50 different positions, protecting 50 different industries. From whom? People that are just

trying to build their s i of living so they can be partners with the United States, and a lot of other problems.

So, I would suggest to you that the major job that lies before all of us, ladies and gentlemen, from here on out, is to use this great society of ours with its unlimited demands, with all its experiences, and with a sense of togetherness, when togetherness is appropriate, to build some sense of the future. Free market, the marketplace would be great. I am the believer in consumer choice in the marketplace in everything, including health and education and welfare, and you name it. But only a compass that is pointed someplace is going to give you something.

And whether it's energy policy, environment policy -- look at all the work we put in to get lead out of gasoline so we can make an industry for you guys. Now we're being killed by Arafat and all the rest of those people. You have the B.S. about what this does to (Inaudible). And we're letting it happen to us. In Minnesota! With all the corn we've got. The signs are going up at all the pumps saying, no ethanol, no ethanol, don't worry, there's no ethanol. In the corn-producing state of the country, practically.

What the hell are we doing? We have pitted our

friends in the oil industry against us in agriculture. And we didn't have to let that happen. We didn't have to let that happen. Now you can see point of most of the oil companies who say, well, all we're trying to do is get their market into the pipeline. Of course, they're trying to get their market into the pipeline. They're trying to survive because their country has a policy that doesn't point to survival for them.

You can't sell products unless they're selling products. There's got to be a partnership, not a big fight! Excuse me, not a big fight.

(Laughter)

SENATOR DURENBERGER: But, there's no place to go. No meeting place for the two sides to get together. There's no place for it. We in the (Inaudible) side can come together with them who are knocking what our product does when next to theirs. So, we're left to fight it out.

I'm getting out all these brochures now in my mail. You get a letter from me and it's got a little thing on ethanol, and it has the truth about ethanol in it. I have to stick it in my mail. And that's why I got a you-know-what (Inaudible).

(Laughter)

SENATOR DURENBERGER: That's because I haven't got any place to get together to talk about these things.

About environmental policy. It's important to your interests. Energy policy. Agriculture policy, and I don't even want to get into that. But wouldn't it be nice if we had a market-oriented agriculture policy?

So, the message simply: we need to broaden our base beyond that policy, giving a sense that they can work that policy to where it ought to be. Then we, together, ought to be thinking about a nation that needs a compass in each of these areas.

Thank you very much for the opportunity to be here.

(Applause)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

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VOICE: We're fortunate to be able to present Senator Dave Durenberger. The Senator is Chairman of the Health Subcommittee of the Senate Finance Committee and is Congress' foremost authority on health care matters. He's one of the major advocates of competition in health care. He was one of the major architects of the prospective payment system and peer review organizations. He is an aggressive supporter of capping the tax deductibility of health insurance benefits, reforming Medicare graduate medical education payments and reforming capital cross-payments under Medicare.

Senate Dave Durenberger brings with him a first-hand knowledge, in addition to all of those previous points, of understanding pre-paid health plans. Minnesota, his home State, is among the nation's highest state welfare penetration states in the country with over 40 percent market penetration in Minneapolis/St. Paul.

Senator Dave Durenberger.

(Applause.)

SENATOR DURENBERGER: Thank you. Thank you all very much.

I usually hope that when someone like Doug introduces me he goes through the list of committees that I

am a member of -- besides the Finance Committee, Environment and Public Works, Governmental Affairs and Intelligence -- because very few people I found in this country believe that the United States Senate has a Committee on Intelligence.

(Laughter.)

It is in that capacity that I run out of the room here periodically because somebody has now made my Committee an issue over a bombing in Lebanon that took place in March, and the good thing about that is it gets everybody's mind off of Nicaragua for a while and our involvement in that subject.

Well, I am obviously pleased to have the opportunity to be here and watch you all serve coffee. Please go right ahead. I usually talk through the main course so that I can get back up on the Hill to do something. So I hope you enjoy yourselves for a little while. I will try to be as brief as possible in my comments, and that's very difficult for me to do because there is so much to be said, so much to be shared, and then I have the -- at this point in my talk I have the real sincere hope that I will shut up before 1:30 so that you have an opportunity to ask questions.

After all, I am supposed to be in the sponge business and some of you have heard me and other fora know -- but I do feel a lot like a sponge in that I go around the

country, when time permits, and we've had a lot of time to go around the country this year, making a little speech about what I learned up to that time. Sort of like squeezing out my sponge. Then I relax the sponge and I listen to the peoples questions and answers about what's going on in New York or some other part of the country, wherever I happen to be.

Then I go off to the next place and I squeeze my sponge on people again and then they react. One of the things I've learned today is that New Yorkers are very concerned about the elimination of deductibility of state and local taxes.

(Laughter.)

And I was to say right now, before I even get to that part of the program when I talk about tax reform, that this is the only place that you care about the issue. So on a scale of 1 to 50 this is not the most important concern as we approach Treasury II. If you want to make it a concern, I suggest you do something besides ask questions of Senators about it because I happen to share your particular concern.

I'm here today courtesy of my publisher and that may come as a surprised to some of you because those of you who think that Senators concentrate on only one area at a time, reality is that I'm also an expert on national security policy and have published a book called Neither

Madmen Nor Messiahs. Now, I don't think we're out of print yet on it.

(Laughter.)

And it's a beautiful book. Whale of a reference work. Ronald Reagan's read it a couple of times and --

(Laughter.)

-- doesn't understand it.

(Laughter.)

He had a free copy. The rest of you are going to have to pay $6.95 to get it. I can't tell you what Solomon paid to get it today.

(Laughter.)

But, I want to compliment Doug on his book.

(Laughter.)

At least mine has pictures in it. I don't know how anybody is going to get through this little -- no, it looks really good and --

(Laughter.)

-- I'm going to take it back and try to read it on the Shuttle between cups of coffee.

I thank you for coming, and I want to compliment you all by saying that you never would have -- you would not have been here five years ago, four years ago, three years ago. I don't know when you started this up here. Maybe two years ago you had one of these things? And the very fact

that all of you are here today to address the subject of the responsive providers towards the emerging buyers market or something like that -- whatever the subject is -- is evidence that something is going on out there.

The other evidence is that some of the people sitting at this table, the folks that are your program for the rest of the day, it's sort of an unusual situation to have a number of the for-profit health care delivery companies in this country all in the same place trying very carefully not to let any secrets out of the bag in the face of their competition, but at the same time to be intriguing enough to get you in some way or another to invest in their opportunities.

That sort of reminds me of politicians. That's much the way we operate. None of us really want you to know what we are doing. We want you to believe just enough so that you will be enticed into returning us to office to take on the wonderful challenges that we all face in this country.

Some of you also may have heard me tell my little Texas joke, and I -- I had to go to Dallas for some reason or other and I needed a short Texas joke. That's an oxymoron. Short Texas joke.

(Laughter.)

So somebody asked me about the riddle, why were

there so many heros at the Alamo? And the answer is because there was no back door.

(Laughter.)

And Texans are not offended by that because all the guys in the Alamo were from Tennessee.

(Laughter.)

So I told it. Then I went on to talk about spending and the political system in this country and it occurred to me that -- and this is what I have been saying to some of you since then. It occurred to me that the Congress has been in the Alamo for about the last ten years in this country. There is 536 of us, including the President, and we are stuck in the Alamo called Washington, D.C. and we have been besieged by the people of this country to do something about the fact that government in America costs too much and produced too little. And in 1976 you all, since you all are out there -- are there any Members of Congress here today? I didn't think so.

You all are out there producing the Jimmy Carters and the Ronald Reagans and all that sort of thing, sending them to Washington to do things like balance the budget, because that is sort of your proof that government can be made more responsive. That somehow or other, by forcing us to live within our means, we will be more responsive in terms of government spending, taxes, whatnot else.

So you gave us Jimmy Carter in 1976 and Jimmy Carter doubled the national debt, did not get rid of the bureaucracy, did not do any of the things that you wanted him to do so you threw him out of office -- and Walter Mondale with him, speaking of famous Minnesotans -- and you gave us a 70-year-old movie actor to be our leader.

(Laughter.)

And the 70-year-old movie actor came on board and he did all the things he was told to do. He cut spending, he cut taxes and he doubled the national debt from $715 billion to $1.6 trillion and it is now, as of Friday morning, on its way to being a $2.6 trillion debt by the time he leaves office. He also tripled the debt service from about $50 billion a year to up -- today it's around $132 or $134 billion, and that's on its way to about $186 billion by the time he leaves office.

So now I'm confused. If the way to get us out of the Alamo is to balance the budget, then why did Ronald Reagan carry every state except Minnesota? I've got a real problem. Well, maybe you don't want the budget balanced, or maybe you don't think we are wasting your tax money or maybe you like debt. I imagine a lot of you are in the debt business. Maybe you do enjoy debt. Maybe you live off debt. Maybe all of us have lived off debt for a long time. I'm going to talk about that today, too.

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One thing we're not confused about, and that is that the Republicans won the election. There is no question about that. And the day after the election Tip O'Neill took his very large Irish body and put it in the back door to the Alamo. The back door to the Alamo. Because the Alamo does -- I mean, our Alamo does have a back door, and every even numbered years I can be seen -- every even numbered year I can be seen, along with my colleagues in the House and the Senate, coming out the back door, presenting ourselves to you for election and telling you that if it weren't for the rest of the people in the Alamo we could balance the budget. We could turn the country around. We could reduce your taxes.

And every person -- you go home after this meeting, if you can remember what I said, go home and look at the last newsletter you got from your Member of Congress, and I'll get you dollars to donuts that that Member of Congress is telling you that he's got a plan for balancing the budget, that he has a way to freeze government spending, that he has either a flat, fair, fast or something form of tax, and every one of them has got one. And every even numbered year we're been coming out the back of the Alamo saying if it weren't for the rest of those people in there, wouldn't this be a wonderful world in which to live.

We have so discredited the institution that it is

now -- at least until last Thursday night -- incapable of addressing your problem. We created special interests in America. It wasn't the special interests that created politicians who pander to 51 percent of the vote. We did that ourselves. The first trip out of the Alamo every one of wet our finger to find out where you were in our particular district, and once we figures out what it took, that's what you got from us.

So if you're looking for and institutional solution to the problems of deficit, living within your means and so forth, it is somewhat difficult to find since we have made it impossible to see the forest for the individual trees, whether it's the senior citizen lobby, the realtor lobby, the home builder lobby, the medical lobby, whoever it is, we have made it very, very difficult for an institutional response to the problems that face this country until this year. Until this year.

On Thursday evening and early Friday morning we produced, on the Senate side by the margin of George Bush's vote, a pretty good spending package. It is not a solution to all the problems. There is no magic in $55 billion deficit reduction or $295 billion deficit reduction. What is significant about that is that there is almost no opportunity for the Democratic House of Representatives to change that. And why is that? Because we've been very

methodical about it. We are up to here in trying to get that one extra vote that we needed to establish the budget.

And here is what we did. In January we went to our leader and we said, Mr. Leader, you won that election. You show us the front door to the Alamo because there's too many of us that are experts here. We will never get our act together. You tell us how to get out of the Alamo. The President said, that's simple. Pass a constitutional amendment to balance the budget, and we all laughed. Literally, we laughed.

And when we stopped laughing, he said, well, I got another idea. He said, I agree that probably it's true that constitutional amendments don't balance budgets; people balance budgets. Politicians have to do that. So he said, here's my proposal. Cut spending down to $144 billion deficit in 1988, and we said, Mr. President, that's not enough. That won't do it. So the Republican majority, which is only a six-vote majority -- five votes with John East being in the Hospital, have to address the issue of how do you cut spending down to a much smaller percentage of GMP.

We did it over three and a half months and in that bill that we passed the other day, we have eliminated -- we have frozen most spending. We have eliminated 12 large programs, including UDAG and some other important programs

here in New York and so forth. We didn't do everything. But we sort of got to the raw nerve of government spending.

I'll give you the Amtrak debate as an example. The Amtrak debate, whether to save Amtrak or get rid of it or something like that, was only a half hour debate on the floor. Fifteen minutes for proponents; fifteen minutes for opponents. So you might have missed it, and probably most of the folks in this room missed it. You wonder why I'm talking about Amtrak at a health conference.

For this reason. The debate went like this. Bill Armstrong, in defense of getting rid of Amtrak said, the future of public service delivery in America is to make users pay for it. If users can't pay for trains, then get rid of trains. Joe Biden got up from the State of Delaware, which has lots of trains going through it -- I don't know if they ever stop, but a lot of them go through it.

(Laughter.)

They must stop because that's how Joe gets to and from work every day. Yeah. Right. So, Joe gets up and says, Bill, terrific idea. Do you accept the notion that all of the Colorado ranchers ought to start paying for their water? And Bill sort of hemmed and hawed and said, yeah, I guess I have to accept that notion. And then he could have, at that point -- he did talk about refugees. He could have talked about education. He could have talked about health

care. He could have talked about quite a list He could have talked about the national park system. He could have talked about the Federal Bureau of Investigation. He could have trotted out quite a list of things that are not in the Constitution but have become a part of the fabric of this country over the last 200 years that you cannot dump on users.

So the really interesting debate that you ought to be watching in the Congress of the United States over the next five years -- and it will take at least that to just get the debate started -- is not over government spending in the sense that we debated it last week and the week before that, but over the role of the national government.

Gary Hart said it to the Democrats, and you all know Democrats are giving each other advice on the future of their Party. Fortunately, only Republicans are listening.

(Laughter.)

But Gary Hart, two weeks ago, told his Party this. One liner summarizes it all. He said, what's important is not old programs; it's old values. And what is going to be happening in this country over the next three years to the next election and then the four years beyond that is a competition to put something meaningful by way of a government role together with old values. My great fear is the Republican Party will spend all its time beating up

on old programs while some creative Democrats are going to be out there finding better ways to meet the values, or the old values.

So, as we translate all of that to what brings you all together today, let me frame the health policy and the health financing issues in the larger context of spending. How do we get the consumer in this country to spend money on the public wheel. We have five basic ways that we do it. One of them is direct spending. This year I will spend whatever it is, $74 billion out of a Medicare trust fund, for the elderly and disabled access to the health care system. I will also pay $600 for a lot of toilet seats on airplanes and $100 for light bulbs and that. But it all totals up to $949 billion in federal government spending.

At the same time I'm doing that, I will encourage you to spend money on a variety of public services as well. I will encourage you to go to work for a company that has free health insurance subsidized by the taxpayers. You work at Chrysler today you get handed a health insurance plan that costs the taxpayers about -- it costs Chrysler and the automobile people, people that buy automobiles $3,300. It costs the taxpayers about $2,200, and you get it handed to you. It doesn't cost you a thing to get it. Just pick it up. There's a little bit of utilization some place in

there, but the reality is up front, here it is. A present from Chrysler. No, not really a present from Chrysler. It's a present from the taxpayers of America.

That is one way to use the tax system to end spending.

Now, there's other ways to do it. I just bought a second-hand Oldsmobile Cierra and paid $9,200 for it with sales tax and everything else. So I went to my banker and I said borrow me $10,000. That's the way we talk in Minnesota. Borrow me $10,000.

(Laughter.)

So he said, how long do you want to pay? And I said, I want to pay nothing but interest, and he said, that's understandable. So he gave me five years and so now on April 15 every year I go -- I do what all of you do. I go get my U.S. Treasury checkbook and I'll sit down and I'll write out an interest -- you know, one-fifth of my interest or whatever it is, write it out on a check drawn on the U.S. Treasury and I'll send it in to my bank and after five years you will have bought me an old Cutless -- Olds Cutless Cierra, and I hope it's still operating five years from now. If it were a Toyota maybe it would.

(Laughter.)

That is the way to spend money, and I could go through a variety of that.

Last year you and I spent $424 -- or this year you and I will spend $424 billion of taxable income in that fashion. Everything from the ITC to ACRS to IDBs to fringe benefits to interest, charitable deduction. A whole long list. One hundred and six, by latest count, of classifications of tax expenditures. That's the second way we do it.

The third way we do it is regulation. You all know about that one. What we add to the cost of an automobile. $1,894 last year, I think, in just environmental regulation and occupational health and safety and all that sort of thing. And we tie that into the health care industry in a variety of ways through the production of drugs and through the inspection systems and various ways. So that's the third way to ask people to pay for the costs of occupational health, safety, the environment, the regulation of investment industry, or Lord knows what it is.

There's a fourth way, and that's called restraint of competition and it is in the -- as long as I'm talking about automobiles, let's talk first about automobiles; then we'll talk about hospitals. In the automobile industry it's called keep the Japanese out. How would you save 26,000 $23-dollar-an-hour auto worker jobs? Well -- without having to raise the money to do it. Well, the way to do it is to keep the Japanese automobiles off the U.S. market so that

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you can raise the price of American cars an equivalent amount to preserve 26,000 jobs at a cost of $165,000 per job and it doesn't even show up, the $2,000 that it costs you to do that per car today. It doesn't even show up on the sticker. On the windshield.

So, you don't know what's happening to you. You pay it when you go and buy the car, but we've saved 26,000 jobs in Detroit and other places in the country. And we do that to a fare-thee-well.

My hog farmers in Minnesota want me to do that to the Canadians now so that they can stay in business, even though they have come down from $15 an hour in the packing houses now to $7.60 per hour. Even though they've made their sacrifice, they can't -- still can't beat the 36 percent differential in Canada so they want me to protect them from Canadian import.

So that's how we do that.

In the hospital business New York State is the best example of how you do it. You just in effect say, we don't want any competition in New York State. I mean, we got big problems in this State. We educate about 17 percent of the doctors in this country. We've got a big percentage of the indigent population in this country. We do all kinds of high tech and research and all that sort of thing in these hospitals. We just can't let these hospitals go.

You cannot let these downtown hospitals go. Where will the poor people go.

So, how do you preserve the current hospital system just the way it is with its inefficiencies, its cross-subsidies, everything else. You do that with some kind of a rate-setting system that keeps the competition -- first you do it with certificate of need and health planning and that sort of thing. Then you incorporate into that a rate setting system of some kind that in effect brings the prices up each year. So every time I go to the hospital in New York I pay an extra 12 percent, 14 percent, 16 percent, and that is a tax to take care of the inefficiencies, the cross-subsidies and whatnot else that go on in this system in New York.

A few other states have done similar things.

So those are four of the ways to get people to spend money on public services in this country.

The first way, and the one that is at the heart of the problems that we face in America, is called inflation. And it's called the excess of demand over supply. It's also called consumption. It's called having today and sending the bill on to tomorrow. It is my parents' generation's gift to my generation, which I am going to be handing off very quickly to my children.

It is the $500 home in the suburbs, with nothing

down other than the $500, forever to pay, very low interest rates and all of it deductible. It is a system in this country that in effect made it possible for us to have, my generation, and I could have that $500 home and I could turn it over because of the excess of demand over supply. I could turn that thing over a couple, three years and make $10,000 a shot, if I were really smart, as the price of homes went up across America.

Why did it go up? Well, very simple economics. I'm proving I've never taken an economics course, but it looks relatively simple to me. If you have 50 million people out there all waving their entitlements to $500 homes and you only have 25 million homes to provide them, what's going to happen? You're going to raise the price of wood, the price of steel, the price of plumbing, the price of carpenters, the price of everything else to meet that demand. At the same time you're going to raise the value of the existing homes for people that already have homes in that kind of excess of demand over supply.

And we have clearly done that in America in a variety of ways using the Tax Code, using free money and other things over the last 25 years.

We adapted that same thing to the health care system and we all did it with the best of intentions and it was premised around access to the health care system. We

wanted everybody to be able to have access to a doctor in the hospital and to avoid catastrophic health situations. So we used community rating, then we used group rating, then we used the employment setting to accomplish that, and in 1954 we used the Tax Code and in the Tax Code we said, if you buy your insurance from your employer, your health protection from your employer, the employer gets a deduction against his tax liability and you get equivalent value in tax-free income.

Employers in this country were then in the position to do for me what I would not do for myself. That is, take my cash, compensation, and buy health insurance. It started out basically as a paternalistic approach to helping the employees in this country get access to the system. It was built on in the sense of competition for good employees. How do you get a good employee? Offer him attractive tax-free benefits package. It was then cloned on to by unions, who said, hey, this is a great place to go to get benefits, and so, pretty soon, before we knew it, we had first dollar coverage of everything but the kitchen sink in the health insurance system.

Through that same period of time, you know, we carried on the basic sympathy for illness in America. The only place you can be rewarded in the work place for not coming to work is if you're sick. If you go to the hospital

they send you flowers, they give you time off with pay. You know, everybody is there to have a little party when you come back. I mean, it's a great thing. You stay healthy in America, though, they make you work.

(Laughter.)

A really difficult proposition. And I was raised in that kind of an environment. I mean, it is better to be sick than to stay healthy. All the economic rewards seem to work in favor of being sick.

With first dollar coverage and the insensitivity to my responsibility for my own health came the same things that we got in the housing market. We got an excess of demand over supply. So we always demanded something better. We got more doctors than we needed. We got more hospitals than we needed. We have more technology. Better technology. It's just an open ended system that continues to grow and grow and grow to the point where in America somebody said, it's got to stop because it costs too much and produces too little.

But the real difficult part of it is the fact that I don't have the right set of incentives and I don't have the right set of choices. I know from the Barney Clark experience with an artificial heart that if I smoke two and a half packs a day for 25 years I get rewarded with an artificial heart out of a near-bankrupt Medicare trust fund.

I know that. I know I will be taken care of. If I have an accident in my car and I don't have a seatbelt on, unless you happen to be in a mandated state, I get taken care of. It does not cost me, other than the temporary loss of my car and the inconvenience of being in a hospital having my check repaired or my head repaired, it doesn't cost me to drive responsibly. It does not cost me to drive drunk in America. Only recently, you know, thanks to MADD and a very other things, is it starting to cost a little.

But go to my accident insurance policy, go to my health insurance policy, go to my life insurance policy and see if you can find in there a real, real difference annually. Every time I paid that do I get any signals that say, hey, you'd make money if you quit smoking. Yes, I understand to some degree it's there, but I've conned my way around it until I quit smoking. But is it there for anything else?

My four boys, when they get to be 16 years of age and get their drivers license, automatically have tripled the premium costs for their drivers' insurance than the girls in the neighborhood do. Why? Because girls have fewer accidents than boys. So what good does it do to tell my child to drive safely and to make sure that he drives safely because there are no rewards. You know, girls can drive unsafely and pay only one-third up to age 25 as the

boys do.

In America today there is not a good set of signals coming back to anyone of any age about health habits. So, as a result, we have gotten up to 11 percent of GNP, most of which now goes into the sick care system in America, and, yes, we can keep people alive. We can do wonderful things.

But, by the same token, my mother long ago, three-four years ago, sent me her living will and it is her sense that she does not want to be a financial problem to this nation. So she has made out a living will, sent it to me, and someday I -- me and the doctor are going to have to stand and decide to pull the plug on her, because it is her perception there isn't enough to go around. It is the perception of the American Medical Association that certain people should be denied entry into life on the basis of some quality of life cost benefit criteria. So, in America there is a sense that there isn't enough money to go around.

I believe the reality is, after you total up all the smoking, all the drinking, all of the -- everything else we do in this society, there is more than enough to go around. More than enough. But how do we get at it? We still have the fetish for the trauma center. You know, everybody wants to be the trauma center, but nobody wants to put any money into accident prevention. Nobody. The

insurance companies don't want to do it. I shouldn't knock the insurance companies. They work hard.

But who's doing it? Who's doing it? The community isn't doing it. The community doesn't see that as their responsibility. They're responsibility is to find some place to pick up the body.

The same thing is true with low live weight births. I mean, performing miracles today. 750 grams and you can keep a child alive. But what's the point of congratulating ourselves about that? So we can put them into a $4,000-a-day neonatal intensive care unit incubator? That's crazy. At least the women in this room know where the best incubator of all is it and we won't put money into the womb. Well, we get them out as quickly as possible, let them smoke, let them drink, don't teach them anything about nutrition, don't teach that poor pregnant woman who is statistically the person who is in most danger in this country, don't help her with that first challenge of delivery. But, save the baby, put it in a $4,000-a-day operation.

I could go on and on -- I don't have to in this group, I guess -- with the incidents in America of misplaced resources.

So, while you can argue anything that I have said (end side one) --

-- the doctor takes care of you, or you show up in the hospital, whatever, and they take care of you. They don't know whether you came from Salomon Brothers or you came from Chrysler or where you came from. No reason why you don't do the same thing with Medicare and Medicaid, or the indigent program. Just -- the only difference is who buys or helps you by the card. The Medicare trust fund may help with the elderly and the disabled and/or the local social services department, human services department, welfare department, whatever you call it, helps the poor buy their card. But when they come in, you can't tell whether they're poor, elderly or employed.

So that is the future direction we'd like to see the financing system, looking at it from a public standpoint -- build the public systems. That is, the indigent, the elderly and the disabled under Medicare, on the same model as the employment system. You contribute part, we contribute part and you buy a health plan with that.

That means we're going to have a lot of health plans in America in the beginning. Twenty-two in Chicago, is that the number? Somebody said, is that good or bad? I said, I wouldn't call 22 health plans competition. That's not competition. I don't even know sometimes whether I call the seven in Minnesota competition. I mean, they sure look like they compete. Open up any newspaper in Minnesota. You

get all the full page ads. You know, they're going bang, bang, bang to get 40 percent of the market.

There's good competition there. But the way the employers out there let them price their product, they're making a lot of money, or a fair amount of money out there. But that's not their fault. They're going to make as much money as they can. As long as the buyer, that is the employer, let's them price their product way up with the most expensive of the employer's existing products, they're all going to make money, and maybe that's a good way to get started in the community. Let everybody make money to make sure you've got a few good companies.

But just the existence of 22 health plans in a community is no indication of competition. So I think this whole process is going to sort out to the point where, as Paul Elwood says, we're going to have 30 big corporations in this country buying health care for people; could be as few as six or eight or ten. I don't know. One of them could be Sears Roebuck, one of them could be Salomon Brothers, one of them could be General Motors. It looks to me like they're poised on the edge of being a big health care company, too.

But we don't know that. We don't -- we just don't know that. We don't know where Hank is going to be five years from now. Maybe he'll be making $18.2 million, like Dave Jones made. But --

(Laughter.)

Sure, more power to him, if he can get away from it. Gave the industry a bad name temporarily.

(Laughter.)

Probably going to lose your return on equity because of it, but --

But we don't know. I mean, right now they look like they're going to be one of the survivors. Everybody in Chicago is on bended knee. You know, they want to associate with them because they think at least in that market -- you know, once humana gets to town, wow. You know, that's a big deal.

But I don't know what it's going to be like five years from now. I don't know who the so-called survivors will be because obviously we can see a change in the re-arrangements. There's all this vertical integration. Everything is going on. The insurance companies are becoming hospitals. The hospitals are becoming insurance companies. All that sort of thing. And I just sit back and I marvel at that. It would be very hard for me to go to a conference and have people lecture me on that it's going to be like because I don't believe them. I don't believe anybody can stand up here and predict what it's going to be like tomorrow or next year or three years from now.

But I'm excited about it because it really is a

market place that -- the difficult thing always is the dog gone politician because we don't understand the market place, a lot of us. We don't trust it. We can't let up on those subsidies, for example. You know, we can't do the deregulation thing. We can't address the poor because to address the problem of financing the poor means we're going to have to raise some taxes, and we're not in the business of raising taxes now. We're in the business of reducing taxes. We want to give money back to New York States and Minnesota and all that sort of thing. Please don't ask me to worry about the poor today because I want those to be worried about down at Columbia Presbyterian and Mass General and things. I don't want to have to think about that. And please don't ask me to give them vouchers or anything else like that because that's highly invisible. That's highly invisible.

So, the politicians will remain the problem. Those subsidies, the cross-subsidies have to come out of the system.

I spoke last week to the Detroit Economic Club and that gave me a little time to talk to the hospital administrator in Detroit. Last year in Southeastern Michigan the bad debt for hospitals was $86 million. The free care was $22 million and the Hill-Burton obligations was $12 million. Now, that's over $100 million in subsidies

stuffed into those hospitals. How in the world can they compete?

You know, you all ought to rush out and buy a suburban hospital in Detroit because you can rip the hell out of everybody else because the politicians won't make decisions about how to handle the indigent. And if you think that's bad, try to get them to make decisions about teaching, about medical education.

Doctor who runs Childrens' Hospital in Detroit told me that the biggest killer of children in American last year was poverty and I believe him. It may not be 10,000. Maybe it's 9,800 and something. I'll bet you the biggest killer of elderly, besides some of the traditional senility or something like that, was poverty also, because the poor in America are getting much sicker. But, you know, while I love competition, I can't stop it. I can't hold it back while the New Yorks or the Massachusetts or some of those other people, including Minnesota, say we can't afford to go to competition because we have this large poor population.

We can't afford not to, and so in the short term, you are going to have problems with those hospitals that are not situated either in the right states or in the right places in those states or at the right mission. That's what we will do with the graduate medical education bill sometime this week to specifically address that issue.

I don't know when we can deal with the adequate financing of the poor in this country. You do not have a Republican Administration that has yet acknowledged a responsibility to the poor at the national level, and you have people at the state and local level wanting the problem to go away, or blaming Ronald Reagan for it and blaming somebody else. Just don't talk to me about the problem.

That is one of the largest impediments to competition right now, is that do we do about the indigent. The good news is everybody is involved in it. All of these hospitals can talk to you about their concern for the indigent problem because they know it stands in the way of genuine choice and competition. The business community is now finally starting to zero in on that. They're getting a little guilty about the fact that we use so much tax money to subsidize their fringe benefits and nothing, relatively, to subsidize the access of the poor to health care. So they're starting to worry about it.

So, what else was I supposed to talk about? I've talked enough. Let me stop at this point, and I can talk about the capital issue, if somebody wants to ask me a question about it.

Yes.

VOICE: Senator, the initial (inaudible) tax reform proposal has in it a provision that says if you spend

more than X dollars a month on your health insurance costs, the overage is not tax deductible. We now hear that that very sensible position is being replaced by a revision which says the first $100 a month you spend for all of your people is taxable and everything over that is tax deductible. And furthermore, we hear that the chief champion of that change is your own fellow Republican and Chairman of the Committee, Senator, (inaudible).

Does that change make any sense at all?

SENATOR DURENBERGER: No. I'd like to get your name, address and phone number because I like you.

(Laughter.)

Bob Packwood is totally against any taxation of employee fringe benefits and so -- but it is he who is responsible for the Treasury proposal, not the Treasury. He is responsible for the Treasury proposal to tax the first $300. It is absolutely asinine. It is regressive as hell and I hate to go to Oregon because he's up for re-election in 1986 and say that. But that is the reality. I don't know what Bob's up to.

One of the reasons, though, you got that is that nobody -- whom you all represent or you individually -- have spoken up, like you just have, for some kind of a cap. I mean, I've been told -- I've been supporting it three years now and now I'm being told by the business community is

forget it. You know, it will never work.

So, I sort of switched off the health cap. We were willing to go for like a $250 a month -- and it's not a cap on the deductibility. It's a cap on the tax free nature of the income to the employee. So the company gets to deduct whatever they want to deduct. If they gave you $500 a month you could deduct $500. But under a $250 cap, the employee would be sheltered on the first $250 and would have to pay tax at ordinary rates on the second $250.

Now, I've sort of given up on that and gone and designed a cap on Section 125 -- the flexible benefits, the cafeteria plan -- because I really think that's the place we ought to be, and we're going to announce in a couple of days hopefully like a $4,200 a year cap for -- family cap, in effect, on the qualified non-pension benefits and then let -- get out of the business of we deciding whether how much of day care should be deductible and how much of legal and how much of health and all that sort of thing. Let the employer and the employee decide that and if the employee doesn't want to buy $4,200 worth or whatever the employer is willing to provide, give them cash and make the cash taxable.

But one of those caps is a much more appropriate way to go, but unless the business community stands up and speaks in favor of one or the other, the whole thing will go down the tube.

Let's see. Yes, sir. In the back of the room.

VOICE: Is there some inconsistency in your encouraging community breaking or the competitive medical plans and then encouraging the national (inaudible) on the other hand?

SENATOR DURENBERGER: Yeah, there sure is. The DRG is basically a regulatory -- I mean, it's a fixed price regulatory system that says the hospital costs the same wherever it is and that's not the way it really is. It is a way to force a more conservative practice of medicine, a more conservative delivery of health care services in the hospitals across this country and we're sensitive to the fact that Southern California is twice as high as a lot of other places and all that sort of thing, and so we're fairly generous in the reimbursement, which means the folks in the south get to make out. That's why they're really pushing for a national average.

So, we're keeping enough money in there we think as we go to national averaging to help even the most hard pressed region of the country. But I'd like to get out of that -- we should get out of that as soon as possible because it is a basically regulatory approach. A fixed price approach is not what any of us are comfortable with. Competition will take care of that. In the sense that these fellows practice competition, will take care of that

hospital pricing from community to community once the competitive medical plan system gets going.

Sir? Yes, sir.

VOICE: (Inaudible.)

SENATOR DURENBERGER: The question of defensive medicine, and I can't give you a lot of the costs. But the problem shows up in a variety of ways. Obviously right now it's showing up in the cost of medical malpractice insurance, the disparity in malpractice insurance from one state to the other, the disparity among specialties. All you have to do is have two big losses in obstetrics and all of a sudden every OBGYN in the country gets a 100 percent increase in their premium. It's asinine. It's really ridiculous.

But the reality is that the -- that side of the system, that is, the adjudication side is out of control and you see it in other areas. Is there a national solution to that? We can't come to a national solution because that's an area traditionally left to the states and the states don't know how to address it. So, we're mucking around in Washington trying to figure out some answer to the problem.

But behind that is a more serious problem, and that is, that in a system where every doctor in a specialty is paid within a very small range, so the good buys don't get any particular benefit and the not-so-good buys are paid

almost the same as the good buys. Pretty soon the practice of medicine goes to hell.

And so one of the things that you do in a consumer choice competition environment is try to reward the good doctor so they go up like that and the no-so-good buys go down. And there are a lot of things we're going in peer review and within the medical societies and so forth to do something about risk assessment, to do something about teaching doctors that there is a safer, more conservative style of medicine that they can practice. But in the end, again -- and some of these guys that run hospitals know this to be true.

I talked to a lot of heads of medical staffs at hospitals around this country about some of these issues, of the way doctors practice medicine, and I am told in many parts of this country you can see it, they would like to deny somebody admitting privileges at that hospital, they'd like to get them off the staff, they'd like to keep some guy off the staff and the guys says, oh, you do that and I will have your you know what in court tomorrow and it's going to cost you X millions of dollars if you try to deny me my professional privileges.

So, there are a lot of people practicing in some of our hospitals in this country that have no business being there. Their peers know that. The folks that run the

hospitals know that. But we don't yet have a system in this country that reinforces within the professional discipline a system for handling some of those people. So that whole thing is now -- is totally in flux. It's a great excuse for the doctors to use for saying, well, you know, my costs are going up and all that sort of thing.

I wish we had an answer and we just don't. I have to admit it. If anybody out here is representing insurance companies or any genius sitting in this room that's got a solution to this problem, I wish you'd let me know. You don't even have to be a genius. Just a practical person.

Anyone else have a --

All right, thank you very much. I appreciate --

(Applause.)

VOICE: We'll reconvene in the conference room -

SENATOR DURENBERGER: -- auto worker jobs. We just said, you pay more for your car, and there it is. You know, we'll just -- they didn't add it to the sticker. I wish they had so we could see --

(Laughter.)

-- see what we're dealing with. I mean, I catch hell for the $600 toilet seats. I don't know why in the hell Lee Iacocca shouldn't catch a little hell for adding $2,000 to his Chryslers in order to save 26,000 jobs. But

he gets away with it and I get stuck with it because I'm in the government and he's in the private sector and he's a great guy and I'm a schluck.

So -- but we do that -- again, we do that in other areas. New York has done that since 1976 in the hospital area, very clearly. I mean, no competition for the existing hospitals, because if you had any competition for hospitals in this day, if you let anybody come in here like Humana or HCA or anybody like that and say, hey, we can do a better job, then all of a sudden these big hospitals that you've got in downtown New York that have all these poor people in them, you know, are going to go belly up. New York would have to raise money to take care of the poor. Right now it's got these big warehouses that will take care of the poor.

But if you ever had any competition in the hospital business those hospitals would go out of business. So what we do in New York is in effect keep the competition out and just let the government raise the prices each year, keep the subsidies in there, keep the inefficiencies in there, keep everything else in there by having a way to raise the prices. So then the consumer, you get sick, you go to one of these hospitals, you pay for the poor, you pay for the inefficiencies, you pay for medical education which you got more -- a hell of a lot more than you need, but you

can't do anything about it because you don't know what it cost, you don't know that it's going on around you all the time. You can't tell a resident from an intern from a pro when you're sitting in a hospital bed so they got you. And restraint in competition enables that kind of a system to operate.

So those are at least -- those are five areas of spending that I've been able to identify that we as a society do and we use government in one way or another and politicians to help us do that. And I think if Ronald Reagan would ever help us to understand that, and when he talks about the Washington Monument, you know, government spending being the Washington Monument and all that sort of stuff, if he'd ever just quit picking on government spending and look at tax spending and inflation and regulation and restraint of competition in that same kind of context, then we'd understand protection. Don't just say protectionism sits out there all by itself as a bad Eve or something else. It is just another way to do some of these kinds of things. It's to maintain pork producers in Minnesota. Keep the Canadian hogs out. I can come up with a hundred varieties of restrain in competition and it depends on whose ox is being gored.

So, I think the interesting debate to watch over the next three to five years in the political sense will be

the development of this kind of understanding. It's all relatively complicated. It's not really complicated, because now that I've said all that I think you all understand what I'm talking about. It's just that you probably haven't heard it put quite that way before. But the reality is that that's the way you'd run a company. Exactly the way you'd run a company. I mean, you'd think of it in that larger context. There are various ways to approach a problem: directly, indirectly, subsidiarially or -- and whatnot else.

And in government, though we tend just to keep it simple, you know, we tend to segregate these things into now we're in the budget. Then we go to tax reform. Meanwhile we beat up on the Japanese. Over here we've killed inflation. We pretend that they are five different games, and of course we're all against regulation. So it's like we're playing five different games and they're -- in reality they're all basically the same kind of game.

So, that I think is the thread that needs to flow through public policy in the next few years, and we very much -- obviously I wouldn't be here unless I felt that we very much needed participation of all of you in that process. You can do it through your PAC.

VOICE: Yes, sir.

SENATOR DURENBERGER: And individually.

(Laughter.)

I like it both ways.

(Laughter.)

I ran in 1982 against a guy who spent $7.5 million of his own money and so, if I didn't have $4 million of other people's money I would not be here to speak to you today. So -- and it's unfortunate that the cost of campaigning is like that, but if you want -- if you want a decent government, that's the kind of price you're going to have to pay.

Having given you that sort of broad outline, I know that within that I could tell you -- and I won't try to detail it. I'll be responsive to your questions in the next half hour.

Thursday and early Friday morning we're really -- it's the first time I can recall sitting from beginning to end on the Floor. Usually you go back and you get a catnap or do something during those long night. But this was an historic event. And the people that were lucky enough to be sitting up in the gallery and just sensing the interplay between the past and the future.

There were a whole slug of Democrats that would love to have voted with us, but they couldn't for the same reason that they -- you have to divide politically in the old context between raising taxes or not raising taxes or

for social security or for a freeze or something like that. They just sort of had to hang together, and in part they had to hang together to test the majority leader and in the end this interplay went on from -- I was in the chair, for some unknown reason, from 7:55 Thursday evening because the people that were supposed to replace me didn't.

(Laughter.)

So, I was in on the start. When they got down to one hour and fifteen minutes left on the bill and the Democrats still didn't know what was in our package, started the tensions that didn't end until 3:15 in the morning, and just watching Bob Dole handle that against Bob Byrd, who is now -- Bob Byrd was all geared up because he had that challenge from Laughton Chiles a couple of months ago. So Bob Byrd is out to prove himself as a leader. Bob Dole obviously has to prove himself as a leader because you can't get any leadership from the President in the While House.

So, that just -- that tiptoeing through the parliamentary process from 6 o'clock to 3:15 in the morning was unusual. Nothing -- at least I've never seen anything like it. I suppose people can go back beyond 1978 and remember something that had that much history to it.

But now that we've broken the log jam, we've proved it can be done, I think there are quite a number of Democrats who will be helpful to us on other issues. One of

those, of course, will be tax reform and I don't know how that's going to be presented. I'm sure it's going to be -- well, I know. In a general sense it will be presented as reform to the income tax because the income tax is unfair and it's too complicated so we're going to make it fair and simple.

We are not going to try and design a national tax system. We're just going to try to make the income tax fair and simple, and I want to tell you I don't think we can do that and get anywhere near balancing the budget. We desperately need to do something about consumption in this country and if we concentrate only on reforming the income tax, I suspect you're going to get another TEFRA, something like that. You're going to end up with a minimum tax. Cats and dogs, as well as some reform. But a lot of cats and dogs. Just for the sake of saying we did tax reform and we will dump other stuff into a general fund in order to finance bringing the rates down.

So, in effect, you'll have a repetition of 1981 and beyond, which is, you know, not bad policy to get the rates down and that in an of itself is a good idea. At least they're not going up. They're coming down.

But if within that you want to do something about the infrastructure in this country -- I mean, whether agriculture or steal or autos or a whole lot of other

things, the energy bill, if you can do anything about the disparity within the American economy, those that are more susceptible to international competition, those that would just love to get out there and compete internationally, if you're going to do anything about those issues, you can't just do it with an income tax. I mean, if you're whole source -- if you're going to try to raise $950 billion a year or by 1988 I think it's $1.225 billion, you can't just do it on an income tax that has a top rate of 30 percent and has charitable deductions in it and has interest deductions in it and has a variety of other necessary business deductions in it. You have to move in the direction of some kind of a national consumption tax.

But as long as Ronald Reagan is President, I don't expect that we will. He just said no new taxes and that means no new taxes. So, if you want real tax reform, I suspect you will be waiting until near the end of this decade. But it will come. You know it will come. You know we're going to be just like the rest of the world and we're going to have to export some of our social insurance costs, for example. Stop sucking them up in American products. Let the folks from overseas who come into this market pay part of those costs and the only way you can do that is with some kind of an added on consumption tax.

There's no good reason -- you can handle it. You

can handle the poor. You can do refundability -- there's a lot of ways to make that progressive. But right now we can't get to it, so my advice to you is to expect limited reform and look out for your own ass.

(Laughter.)

In that kind of a context because there is only so much room to negotiate to get those dollars. Well, that's how 936 got on the plate in 1982-83, whenever we went at it. It was just -- we had to get a couple extra bucks, and that's how it got offered up.

I got to shut up here, but as long as I mentioned 936 I'll just tell you what you already know, and that is, that a lot of Minnesotans are doing business in Puerto Rico so I have a fairly strong interest in 936. But, in the larger context, I have a strong interest in Central America and the Caribbean. It's been manifested lately by my Chairmanship of the Intelligence Committee, which is a great frustration to be on there with a bunch of heros like my Vice-Chairman, who I see this morning is trying to make himself a hero again.

We are badly botching our policy with regard to Central America and the Caribbean in large part because we don't understand it because it's so close to home. It's a -- for most people it's a sand beach that you go to for a week at a time, or something like that. It isn't understood

in terms of people and the potential for productivity and a limited impact on an American market, but a huge advantage to some of those people to be able to get into an American market.

I think the concept of 936 expanded to include other people, other than the health related, is one very essential part of a regional economic development policy that at least covers the Caribbean and Central America. The Jackson Plan has that kind of potential in it to do that kind of good. But unfortunately its got an $8 trillion or $8 billion price tag on it, and so we will be reluctant to deal with $8 billion, and yet -- I guess you all know something about these countries.

They're relatively simple economies. They are not all that demanding. Looking at some of these flowers here reminds me that I spent a week in 1974-75 or something with our manager in San Salvador and went out to his little two-acre farm where he produced -- what's that very expensive flower? Well, anyway. In this country at least it's a very expensive flower because it comes from Hawaii and the Hawaiians get rich off of sending it --

VOICE: (Inaudible.)

SENATOR DURENBERGER: Probably.

But he's two or three or four family on his little two-acre farm down there living off of producing

these flowers. But he can't get them into the US market except he pays a great big $2 per flower import duty or something like that because the Hawaiians won't let him in. And you know, even if you plowed up all of the little two-acre plots in and around that volcano there outside San Salvador to turn them into flower producers, you wouldn't make that big a dent on the US market. But we won't let them in. We won't let them in to print some kind of printing inks. We won't let them in for a whole lot of that sort of thing.

So, there are a lot of relatively simple things we could do for that economy in accessing them to our market place. But how we're ever going to come to grips with that in the current environment and with the current talents that we have in this Administration, I -- or even the Congress, I really am at a loss to see it. I would hope that you all might play a role. Those of you who do business in the Caribbean and Central America might play a role in elevating the notion of the Jackson Plan up in the importance of things that we do. You know it. You've done some business there. My company does lots of business. It's a very small company, but does it in all those countries.

But they're frustrated. They can't get it going. And I think maybe in the business community in this country we've been a little lax in -- maybe the problem is that we

look selfish when we talk about these sort of things. It looks like we're trying to get (inaudible) and you shouldn't feel that way. I mean, you know what you're doing for the Puerto Ricans. Yes, it has some benefit to you, but look what you're doing for the Puerto Ricans. Much better than our welfare system down there and not having them paying income tax.

But maybe you need to broaden the scope of that in order to make it a little bit more appealing.

I think I have said enough. I'd better shut up and respond to your --

(Laughter.)

(End side two.)

VOLUME XII

EXHIBITS 235–246

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics by
Senator David Durenberger

DD Speech to the

SECURITIES INDUSTRY ASSN.

MARCH 4, 1986

RE: TAX LEGISLATION

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EX. 235

THE CHAIRMAN: Its title, however, could apply to countless issues and reflects the balanced approach with his own legislative style. Please welcome the author of Neither Madmen Nor Messiahs. Senator Dave Durenberger.

(Applause.)

SENATOR DURENBERGER: Thanks.

Thank you all for being here. I did bring some of my books with me --

(Laughter.)

-- for those of you who travel on airplanes long distances like I often do, I thought I would share some of them with you, but first it's -- I always enjoy being introduced as the chairman of the Senate Intelligence Committee, because many of you know what an oxymoron is.

(Laughter.)

Two inconsistent words. I can tell some of you do already.

(Laughter.)

And when I say "Senate Intelligence," that's an oxymoron.

(Laughter.)

And I used to be on Senate Ethics as well.

(Laughter.)

Even more difficult to explain to some people.

Well, to the books. I made a long trip this weekend to help Chuck Grassley with the Home Builders. He probably doesn't need any help, but they're interested in some of the same kinds of issues you are, that is, access to the market for that part of the infrastructure called "shelter" in America, and so I read a couple books, and I thought I'd share them with you.

First is -- since I am on the Intelligence Committee, there's a terrific book about the CIA and the State Department and how they relate, and then Bob Ludlum's latest book, The Foreign Supremacy. I just couldn't put it down. It traveled on at least four different airline with me, and it's an absolutely terrific book. It's better than Iacocca's, if you want to know the truth.

Secondly, is -- for those of you who are interested in current events, you watch the President on television, you want to know more about a little country that I used to invest in when I was with a specialty chemical company, in fact, spent a fair amount of time here

from -- in all the Central American countries -- from 1971 through 1978. And there are several good books out. This one is the more in-depth book, probably, on Nicaragua, which is called "Revolution in the Family," and that is by Shirley Christian. And Shirley spends a fair amount of time going back into a little bit of history of the revolution in Nicaragua to give you a background as Americans to -- for the issue that we are currently dealing with.

I suggest that to you for your reading only because you are about to be dragged into a little war again in Nicaragua without your knowing about it and on the presumption that all we are doing is defending democracy, and besides we need a left wing to topple now that we have toppled a right wing.

(Laughter.)

Third book, the one that bring me here is called Neither Madmen Nor Messiahs. Maury's already told you that. This is a little book that I put out in 1984, I think, the fall of '84, on national security policy. It's a terrific book, not selling a lot of copies.

(Laughter.)

You can still have it for the original price -- 6.95.

(Laughter.)

Available at B. Dalton or from my office.

(Laughter.)

Right now, it is particularly good, and I know Tad has read it from cover to cover, and Stan, you've read it from cover to cover, right? And not because they know me well, but I think they would endorse it as a -- if you want to know how to measure national security in something other than dollars, this reflects the kind of thinking that is going on and about today, in probably about 35 to 40 percent, maybe more of that, of the Senate and the House, by way of a restructuring of our approach to national security

So that I will rec -- since that brings me here today, I will recommend that to you.

The fourth, I'm just going to show you, because I don't think it's generally available, and I am going to explain it to you as part of my comments, is this. It's available from the Government Printing Office, I think.

(Laughter.)

It's H.R. 3838.

(Laughter.)

It weighs 4-1/2 pounds; it has 1379 pages, about 3900 sections, and it would take the thoughtful person about 46 hours to understand, but you haven't got 46 hours, so I'll give it to you in about 30 seconds, by way of illustration.

George Bush, last year, the last tax year, was in

the 12-1/2 percent marginal bracket; I was in the 45 percent marginal bracket, with less income than George.

(Laughter.)

This is an effort -- this is an effort to get George up to 25 percent by promising me I can come down to 35 percent.

(Laughter.)

That's -- that's what this is all about.

(Laughter.)

Now, I don't know which one of those you want --

(Laughter.)

I don't know which one of those you want to start on. I would recommend Ludlum's book --

(Laughter.)

-- among -- among the four of them. But we have to talk -- Malcolm's talked, Pat's talked, and I intend to talk, though briefly, about H.R. 3838, because it will best illustrate the frustration that we all share up here from this -- from this podium and from the one I just came from, where some of the tax-exempt people are testifying on behalf of public benefit bonds, if you want to call them that, right now, on the Finance Committee. Our frustration on not having any tax principles to deal with. All we have to deal with is George and Dave. Political principles. Thirty-five percent top rate; 36 percent top rate; $2000

exclusion and revenue neutrality. Those are not tax principles. Those are political principles. And everybody knows it.

We have started tax reform at the beginning of this decade by chopping off the top of the hills in this income tax system of hills and valleys, by cuttin' off the top of the hills with rate reduction, ACRS and -- and then the -- in -- in the tax bracket in there. Now you've got to start from the bottom and fill up the valleys.

How do you fill up the valleys? In a political sense, promising the top of the mountain that they are going to come even further, and you just gradually are going to compress the difference between the two.

So we are faced with a set of political principles, but the current discussion is all on savings, investment, consumption, all of that sort of thing.

But you can talk about that until you're blue in the face. If I don't have it in front of me as a guiding principle to take me into conference with Ways and Means, what good is it? What good -- it's just a -- it's an intramural debate between one body that is going to take money from corporations or institutional sorts of op -- income-earning operations and transfer it in one way or another to individuals. That's the argument coming from one side.

One our side, we are supposed to be closer to business and investment and savings. So the argument is that we will somehow or other be sensitive to capital formation and all the rest of those opportunities. Yes, of course, we'll be sensitive to them. But so are the folks on Ways and Means. But neither of us have been provided with any set of tax principles to guide this debate.

So in the end, you will find, I'm sure with Malcolm, a frustration in even dealing with the problems of tax reform, because in large part we can't get comfortable with the political principles that are involved.

Now I have a whole bunch of constituents at home -- my state is divided right down the middle. Half of my constituents say don't do any tax reform at all. You've been doing too much, you know, let it alone for five years. You know. Forget it. The other half find themselves -- finds the first half to be George Bush. They look at the agricultural industry. They look at forest products. They look at mining. They look at the basic industries, transportation, in my State. They look at half of my State; they say that's George Bush. In fact, they're under 12-1/2 percent. They've got all the breaks in the Tax Code. They aren't producing any jobs, and they aren't producing any investment. They say, come with me to the other end. Come with me to the Dave -- Dave's end of the Tax Code, and I

will show you at (inaudible). I will show you at 3-M. I will show you at General Mills. I will show you at Pillsbury. And they go right down the line in my State.

They say, who are the biggest employers in my -- in your State, Senator? Who are the people who are adding employment? Who are the people who are making Ronald Reagan look good. Who are the people who are investing in America? It's not the folks down below, at George and below, in a corporate sense, it's the folks up around Dave, and we ought to bring them down to 33 or 35 or 36 or wherever you can get them.

So I am a typical Senator, perhaps, maybe untypical in that my State is split right down the middle. want to say on behalf of Tad Piper, he is on the side of "Don't mess with the Tax Code."

So that's -- that is -- that is a typical situation. Now do you resolve that situation? I'll tell you how I would like to resolve the situation. If I'm going to do Federal income tax reform, I do it on the basis of why people earn income. First, to have some money for consumption. Secondly, to put a roof over their heads, food on the table, health care for their family, that sort of thing, secondly. When government taxes people's income, have in mind why they earn the income. Thirdly, why do people earn income? For the rainy day. They can't work all

their lives. They are not going to, you know, die behind the desk, most of us aren't. Retirement, disability, pregnancy. Periods of time in which we won't work.

So all of us earn income for those kinds of purposes. So when government taxes that income, keep in mind, that part of my reason for earning it is that.

Fourthly, when I earn income, part of it is to provide safety for my home, safety for my children. That comes from police and fire in my local community. The street out in front of my house, a sewer, water, environmental protection. A school down the block or somewhere. Now where do I by those services in America? I buy those services from state and local government, and so I have -- I earn part of my income in order to make the purchase of those services in my local community that I need so that I'll stay in that community or in any community.

So when you tax my income, Mr. Government, keep in mind why I'm earning it, and you will affect how I earn that income or what kind of income I earn. In America, those of us with more talent than others, also put a little more effort into working a little harder, so that we can earn something to help those less advantaged. And that is just an American tradition that's always been part of being an American. And we share that with other people. And it's been blessed with 501(c)(3), (4), (5), and that sort of

thing, but it's stili just part of us. It doesn't have to be -- it's not tax policy. Tax policy came along after we created our churches and our association and reaching out to the person next door. That's just part of America.

And so part of what we do as a people is that, and when government decides to tax our wherewithal, government ought to keep in mind (chuckling) that's -- that's one of the reasons that we produce wherewithal.

Now those kinds of things, it seems to me, are the essence of which tax principles -- income tax principles -- are made. But we don't have any of that before us in the Finance Committee or Ways and Means. It's nowhere to be found, except up here in the speeches that Senators give. But when we get 20 guys sitting around a room, those aren't the principles. The principles are the same as they've been for the last five years. The first year it was, we can afford 41 or 42 billion dollars in revenue foregone, and so our objective in 510, PEN(?) and ACRS and everything else, was to stay within the first year, $42 billion tax loss.

The second year -- what was that called, TEPRA or something like that, in the second year, 1982, our objective was to raise $96 billion. And so we came along withholding -- the last plug in the dike was Durenberger, in order to get some safe harbor leasing, had a vote for withholding of interest on taxation of -- or withholding of interest

(inaudible), and then I lost most of safe harbor, and they stuck it to me in one way or another.

(Laughter.)

So -- but anyway, the objective was to raise $96 billion, all of the revenue and all of the amendments, and everything was geared to that. Lat year it was similar, in '84. We had a dollar goal. And this year it's the same thing. No principle involved.

So I give you that as a framework for your involvement in the process. I mean, if you don't like the way we're going about this, if you like the way we're going this, keep pushing. But you know tax reform will not end with the Senate passage of H.R. 3838, because until we get to the reform in America that deals with why people earn income, we aren't going to have genuine tax reform, and until we establish a national policy of taxation, we won't have it either.

The national government has switched, clearly, over the last 30 years from taxing wealth or property, as a nation, to taxing income, and everybody knows that. We do not tax property to any great degree at the national level. We leave that to some other level of government to deal, with. We tax income. One of the reasons we did is a lot of people after the War fled the inner cities and created suburbs and things like that. We had -- but they still

worked downtown, so we needed some way to get at them when they went to the suburbs, so we could take their money back downtown where they weren't paying property taxes any more. We follow them out to the suburbs, taxed their income, bring it back downtown in the form of grants and things like that.

So there are reasons why we have done all this, why we've gone to heavy tax on incomes. But in order to keep that tax system flowing, we had to create inflation. There are lots of other reasons we created inflation -- the desire to have an (inaudible) and the desire to turn this into a consumptive society. All of that sort of thing created that kind of a tax system.

But it also put an additional heavy burden on income, called the payroll tax(?). This is one that nobody never talks about, and yet it is the one that drives me crazy, because I can't look at a person under 35 today and promise them there is going to be any Social Security there when they retire, because I know there won't be. If we don't change anything, nobody under 35 today will ever get any Social Security. But this year, every one of you is paying $6000 into the Social Security Trust fund. In 2-1/2 years, you will pay $8000. If you are the head of a family with someone who is working in a similar $42,000 or above job, you're paying in $12,000, and you will be paying in $16,000, and there is no exemptions. There's no deductions.

There's no nothin'. It's just first dollar you start paying it, all the way up to wherever we quite.

So just look at a society that's taking $16,000 per family or $8000 per person in this decade out of people for a system out of which they will get no benefit, and ask yourself, shouldn't we pay some attention to that part of it. Now, we complain about the comparative costs of labor between the United Statea and Taiwan and places like that, but we never mention the payroll tax. And on top of that Social Securicy payroll tax, the States puts -- or the Fed and the State puts unemployment comp. On top of that, the States put worker's comp. See, that's -- that's the totality of the tax on labor in America. But we're not paying any attention to that, except in a generational sense. Those of us who care about our kids are worried sick about the payroll tax.

But if a nation is going to examine itself and say how should we raise funds for all of these various purposes for our citizens, shouldn't that nation took at the totality of the tax on income and not just a part of it? Clearly, we did this fairly deliberately -- I don't know that we knew all the consequences, but fairly deliberately after the War we decided to go to consumption in America, and we put all the benefits in the income tax into consumption, and we put all the penalties into savings and

investment. We even called the savings investment income, unearned income, so that we'd have a pejorative to hang on it. So the people wouldn't do it.

Is it any wonder that we find ourselves in a fix where we're debating 401(k)s and 403(b) and IRA offsets and all that sort of thing, when we have had to build back into a system in which we destroyed saving dividends (?). We have had to build back some way to hang onto (inaudible). But this year you're not going to get that kind of debate. You've going to get that kind of discussion from all of us, because we're at least average intelligence, at least average age in America. We have all had similar lifetime experiences, and we all think this country ought to learn to live within its means, but you can't get there unless you have a map or a compass of something to point you in that direction.

We can't have half of my state going off this way saying "No, save the basic industries at any price," and the other half of my State going off and saying, "You know, we don't do tax investment. We do investment for the good of America. We want the rates down as low as possible, so we're not penalized for those decisions." And that down the middle, there isn't anything other than Dave and George. "Hey, Dave, how'd you like a 35 percent rate?" Well, this Dave doesn't want a 35 percent rate, because his biggest

problem is the deficit. His biggest problem is that he voted time and time and time again to balance the budget, not because it's an economic necessity, but because it is an economic, social, political, moral necessity to learn to live within our means, and if we don't start it here, you aren't going to do it in your own life, and we are all the generation that was brought up to believe that we can have without paying for it.

You wonder why hospital costs are going off the roof. Because we don't pay for sick care in America, so we have used(?) like mad. Or housing, or a lot of other things. So we're all in this sort of effort to turn ourselves around and to try to find some way, not in a literal sense, but in a figurative sense, to learn to live within our means.

I think there are a lot of people on the Hill who are ready to do something about it, but to find the proper role for the Federal Government and for us decisionmakers -- and this is very difficult without your help, without our help -- you have to understand where the Federal Government is heading. It is heading for the Pentagon, the Social Security Administration and the T Bill operation of the Treasury Department, in effect, where it's headed.

Defense spending is going from 23 percent of -- from one of the decade from 23 percent of Federal spending

up to 32 percent of Federal spending. Debt's going from 9 percent to 17 percent. Entitlements are going from 42 to more -- to 37. They're actually going down as a percentage of the total. But all other government's going from 26 to 16 on current spending.

Now this year the President says take another whack out of that 16 percent. He told you in the speech, 5 cents on domestic policy is all you need. A nickel on a dollar for this year will do it. Well, that would take that 16 percent down to 14 percent. And every time you do it, something else goes. And it's not fraud, waste and abuse any more. That left a hell of a long time ago. The outright fraud, waste and abuse. That left with converting categoricals to blocks and a lot of that sort of thing. But general revenue sharing does, UDAGs go, CDGB goes. I mean, just to concentrate on one of the areas which I know a lot about, which is the intergovernmental system. We're just peeling it all off. And back goes the responsibility, without the resources to pay for it.

In fact, we do the resource thing the other way. We said we wouldn't get in the excise tax business, but we took the gas tax from 4 cents to 9 cents. We said we wouldn't get in the cigarette tax business. We took that from zero to 16. And deductibility of State and local taxes. Since 1913, we've had deductibility as a way to

match those decisions that States and local government made to respond to people's needs with a Federal -- with a Federal match. Now we're going to get rid of that. Now tax-exempt bond financing. Get rid of that.

So what's going to be left? What's going to be left? You know, the difference between Minneapolis and Edina. Edina is our richest suburb. Difference between Fairfax County, Virginia, and Washington, D.C. That's what you're going to have left in America.

When Jim Baker came in to testify for deductibility -- or the elimination of deductibility in State and local taxes, I sent somebody out to find out how many undocumented workers there are, people, illegal people in this country. In New York City, not in the suburbs, not up in Connecticut or down in New Jersey, but just in New York City, how many undocumented workers. And they came back with -- maybe the mayor inflated this a little bit, I don't know, but he said 751 or something -- 750,000 undocumented workers in New York City. I said, Mr. Secretary, do you realize that's more people, by 200,000, than there are people in Wyoming? You're complaining on behalf of Wyoming that all the money's going to New York on deductibility. Well, dammit, New York's got 750,000 people that shouldn't be there. But they have to take care of them. All those big hospitals down in Manhattan are all

taking care of those folks. You don't turn them away; you don't dump them in the river because they can't produce a citizenship certificate.

There's no Wall Street in Cody, Wyoming. There's no Metropolitan Opera in Cheyenne. We are different as a people, but that's what makes us so great, because we are different.

And so a national government needs to find those ways to let Wyoming be Wyoming and New York be New York but not make it difficult for a person who can't vote with their feet to live in one place or the other.

So that is the kind of search that is on right now, that the -- the great value of Gramm-Rudman, that decision to make decision is just that we are going to start debating national purposes in this country, and that's where you-all come in. Your special interest is also our general interest, but your general interest also ought to be our special interest. And there's never been a better time to be in the Senate, the House or where you are right now, because that is the debate that is going to start.

The President says get rid of Amtrak, because it's an unfair competition with the automobile. I say, (inaudible). The car is unfair competition with a national rail passenger system of some kind. Well, I don't know who's right, but dammit, let's start talking about that.

Let's start debating that.

Right now, there's a debate. There was -- I just left from a debate between Domenici -- and it's not a serious debate. Domenici's testifying, and George Mitchell and Bob Packwood were asking him questions on infrastructure and tax-exempt bond planning(?). Pete and I are on Environment and Public Works. We both believe that ought to be Environment. Chop off Public Works and send it back to the State and local level; we have no business building freeways in Boston and filling potholes in West Overshoe, Minnesota. So Pete is saying, you know, we need an infrastructure system under economic development in America. Bob Packwood says, well, where do you draw the line on government purpose or public purpose? He always drags out this guy from New Jersey who came in and said, anything that creates jobs is a public purpose. Therefore, we ought to be able to use tax-exempt bond financing. And Pete says well -- and they ask Pete, would you agree with that? And Pete says, yeah, as a former mayor of Albuquerque, you bet. You have targeted job tax credits, don't you, in your Tax Code, why the hell not have tax-exempt bond financing (inaudible) will build jobs.

Well, they both then acknowledged that in the refinement of public purpose or governmental purpose we may need to -- may need to be a little bit more specific.

Then George Mitchell said the logical, asked the logical, which is, tell me, on an efficiency scale, what's better, to give a direct grant to local government to build a hospital or a sewage treatment facility or solid waste facility or something like that or to use tax-exempt bonds for that?

And Pete said I don't think, in effect, it's that easy.

And at that point I said it's not that easy, because if you look it, pure efficiency -- take out all other factors -- pure efficiency would tell you that general revenue sharing is about 99 efficient. In other words, you (inaudible) cost about $1 on $100 to send the money back and let those people make their decision.

Block grants are probably 88 percent efficient. Categorical grants are 82 to 85 percent efficient, and the efficiency of tax-exempt bond financing depends upon the spread and how much revenue foregone we have to -- we have to put into the system. At one point it was 65 percent, probably up to 70, 72 percent.

But that's not the way to measure efficiency. Efficiency is built on the way the decisionmaking system works. We have been debating a water resources bill since 1977 without passing it. So the cost of a flood control project in my State has gone up from $22 million to $68

million, and we haven't turned one piece of ground. I've got 300 -- I've got three interstate highways in Minneapolis-St. Paul and Duluth that would take $375 million to finish, but when they were first proposed, if they had followed out the logical course of building it, it would have cost $72 million.

So I said, Pete, don't you think the market works a lot better to make these decisions than does the Public Works part of Environment and Public Works? And he says, damn right (?). That's why we ought to have (chuckling) tax-exempt bond financing.

So this is the debate. You know, how are we going to participate in those standing decisions? How are we going to subsidize decisions that have to be taken at some other level? Are we going to abandon it? Are we going to say there's a trillion dollars worth of infrastructure needs in America today, but they ain't my responsibility?

Is that what we're going to do? I can't imagine our doing that. I can't imagine our doing that.

So, you know, I've taken the lead on redefining the tax-exempts and -- I've talked myself out of time.

So, the bill will be ready, hopefully, by the end of this week to go in. In effect, we have taken the old essential, nonessential categories, converted them into governmental, quasi-governmental.

Governmental bonds are those where no more than 25 percent of the benefits are used in a trade or business, where no more than 25 percent of the revenues derive from a trade or business.

Quasi-governmental bonds are those that exceed either test.

Three categories of projects are covered within the definition of governmental:

Publicly owned and operated. That's one.

Publicly owned facilities operated by a private party under a management project, like airports, convention centers, irrigation systems, et cetera.

And the third category is public service facilities owned and operated by a private owner. Water, sewer, solid waste, that sort of facility.

Multifamily housing bonds and tax increment bonds are deemed governmental and not subject to any volume cap. There's no volume cap on governmental.

Quasi-governmental bonds would be capped at $225 per capita per State or $260 billion whichever is greater. Included in this category are single-family mortgage bonds, veterans' mortgage bonds, student loan bonds, private loan bonds, bonds issued by section 501(c)(3) organizations -- although I'm not sure that that's where that one ought to be -- small issue industrial development bonds and industrial

park.

On advance refundings, the only bonds that could be advance refunded are those in category 1 of governmental bonds, that is, publicly owned and operated, section 501(c)(3) bonds issued by nonprofit hospitals. Such bonds could only be advance refunded twice and the aggregate amount of refunding bonds would not exceed 250 percent.

If you don't like that, please tell me, because we haven't put the bill in yet.

Early issuance restrictions. Five percent of quasi-governmental bond proceeds would have to be expended without 180 days. At least 20 percent of the proceeds of governmental bonds would have to be expended within the first year or the bond yield would have to be restricted. Five percent of the proceeds of student loan mortgage subsidy and veteran bonds would have to be committed within 180 days or the bond yield would be restricted.

On arbitrage, issuance of category 1 governmental bonds could earn unrestricted arbitrage for a temporary period not to exceed one year. For construction projects, the temporary period could be extended by one year, if at least 20 percent of the proceeds have been spent for the purposes of the issue. The temporary period could be extended an additional year if at least 50 percent of the proceeds have been spent within the first two years. If the

issuer fails to meet the spending requirements, the temporary period terminates and the yield is restricted. Quasi-governmental bonds and category 2 bonds may only earn unrestricted arbitrage for six months.

That is the basic outline of the bill as it stands right now, and we've spent a solid three weeks with three or four people's staff time and lots of others working on that with a whole lot of the interest groups in this country.

So if you want to make any comments or suggestions of how to improve that, please let me know fairly soon.

Thank you all very much for the opportunity to be here. (Inaudible.)

(Applause.)

(Whereupon, the presentation was concluded.)

(End of tape.)

TRANSCRIPT OF PROCEEDINGS

Transcript of Tape Recording Provided to the
U.S. Senate Select Committee on Ethics
by Senator David Durenberger

10-7-85

Durenberger Speech to

U.S. Chamber of Congress

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SPECIAL
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EX. 236

(Transcriber note: The following tape was poorly recorded; much of it is not clearly audible for proper transcription.)

SENATOR DURENBERGER: -- (inaudible) just got on Cable News Network and (inaudible). And things are going great, because we picked up DiConcini and Bentsen. I think we'll probably get 61 votes (inaudible).

So I bring you that as a barometer --

(Laughter.)

-- of tax, fiscal, monetary, economic politics in the Nation today. The one thing we all have talked about, of course, is that -- Bob Dole on television this morning was much more persuasive than Bob Byrd, because Bob Dole said we are in the business of balancing the budget, and Byrd came on and said I am afraid that we will hurt these people by cutting their spending and somebody else by cutting their spending (inaudible).

Probably the one thing that most of us are agreed

on is that the biggest issue in the country today is the size of the deficit and the inability of this process to deal with it. And Gramm-Rudman is just a manifestation of a tool that a very frustrated body, the Senate, has pulled out to try to use to fight the problem. I'm not sure whether I will vote for Gramm-Rudman or not. My great fear is that -- I get two kinds of advice on it. My fear is that we're going to do five more years of budget legislation, that the only thing that is going to happen in this country is the budget process, and if you didn't make it on board the budget process one way or another, then nothing -- then nothing gets done.

If you know anything at all about me, you know that I am a reformist. My first speech on the deficit was in November of 1981, and basically, the content of the speech was that if you want to balance the budget, you are not going to do it by cutting spending and taxes. It just cannot be done. You're going to have to reform the way we meet the needs of the public in this country, and that is, not only do I continue to believe that, that is still the reality. You are not going to do it simply by raising taxes, because Ronald Reagan won't let you raise taxes; you're not going to do it by cutting spending, because there isn't $215 billion worth of spending to be cut from that budget. Given the nature of the generational problems we

have in this country, it cannot be done.

So the bad side from my -- the bad news from my standpoint is, why should I sit around here for five more years doing nothing but a first budget resolution, then reconciliation, and then a sequestration resolution, which would follow in October or something like that.

The good side of it, having when I think try to -- not a good side of if, but when I try to think positively about, is that we may well do that anyway. We'll certainly do that for the next three years, as long as Reagan is President, if that is all we're going to do. So why not get something for it. If all you're going to do is the budget resolution and reconciliation, why don't you try to get something for it like -- like a balanced budget in 1991 and go, you know, one of the -- I guess one of the practical things I've got to decide in my own mind is whether the bad downside outweighs the -- or the good side outweighs the bad side. The good side only being that we're going to do it anyway, so why not use this as a vehicle. But I can't predict the -- for you, how any of it comes out.

One of the lobbyists for the Needy in America capture me outside the floor yesterday and -- or they all stood around the elevator protecting their particular interests. But he had dragged out a speech I made a few months ago at which I argued against freeze -- spending

freezes as policy. My argument was that only a small part of the spending in this country takes place in direct spending. A large part of it takes place in other places, starting with taxes, for example, $300 and some billion this year in tax expenditures, but an even larger amount is in things like -- in subsidies. Import quotas have raised the price of automobiles in America by what, the current wisdom, $1200 a car, $1500 a car. Something like that.

The same thing holds true of anything else, where you keep competition off a market. In the health care area we did that for the better part of a generation. We kept competition out of the field, thus raising the price of everything we did and using the increased price to subsidize the poor and to subsidize (inaudible), education and things like that.

So my point was there's a whole lot of spending that goes on in this country that doesn't show up in the difference between our revenues and our outgoes. And he dragged that out, and he said, you know, between now and the end of this decade, tax expenditures are going to go up $191 billion. So you're going to sit here and you're going to beat up on the needy and the Defense Department and all that sort of thing for five years trying to bring that line down while the tax expenditure side is going to continue to explode, which brings us to your $119, $117 billion a year

worth of tax expenditures in the employee benefits area. That one will continue to rise.

And while -- while -- like farmers and those sort of go under (?) because they don't have any health insurance, you will continue to feed the health insurance hog by increasing your premiums and doing all that sort of thing at my expense or at somebody else's expense. And that one will be substantially larger at the end of this decade. I don't know what that will get to be, but that one will continue to go up while all these other things are in one way or another put under some kind of control mechanism.

So it is -- that is sort of in summary why I come to people like you sort of pleading for some help in reforming the system and redesigning it and saying, hey, you know, we aren't going to be able to do anything smart in that policy(?) on employee benefits until the folks who are in the benefits business give us some encouragement as to where we ought go. And so far, we've had encouragement, but obviously no consensus, and I don't expect that in the near term we can get consensus across a business community as varied as this one.

I have sensed a lot of deep concern, a lot of fears. There are a lot of people that are desperately worried that in our anxiety to get to a flat tax and all that sort of thing, that we are going to take things like

health insurance premium caps and stuff like that, we're just going to ratchet it around, keep screwing them down till there's nothing there. And I guess that's a legitimate concern to have, but it is impractical to think that that's what we would do on -- it is not going to happen. There are too many Americans out there that one way or another can -- I mean, nobody in this country can afford health insurance today, but the bulk of them are in employment status, and they are going to insist the maintenance of that kind of a premium benefit. So the notion that even if you took a $300 premium cap like Rostenkowski has in his proposal or a $250 a month cap like we have in ours, then we would then, instead of taking that up with the Medical Price Index or something, we would start to take it down to nothing. It just -- it isn't going to happen that way in this country. We are not that powerful in this place.

So you can have evidence of 401K. One day you said we can have 401Ks, and the next day the President came along and we're going to take them away from you. But he hasn't taken them away from you -- we haven't taken them away from you. The President can't take them away from you. At some point in time he might. I mean, if we do nothing long enough and our desperation becomes great enough, it is possible that we might do something, some things like that. But I find it really highly unlikely that this place is

going to operate in the future the way it was operated in the past.

Now what is lacking in the sort of a framework for good tax policy, and I'll just say these few words and then shut up and listen to all of you. But one magazine I read every week is "Business Week." And I guess the latest issue, the one that tells you you ought to be in the information business, right? Well, in the front of it, I found lots of interesting things, but one of them was a little article by Willard Butcher in which he sort of takes off on the issue of tax reform and that sort of thing. And I started to write him a little letter before I had to get together with Jim and come down here, but I should have brought the thing with me, because where it says, you know, we need -- the only one -- I think the gist of the article is that the only way you're going to beat competition is not on wages -- of getting wages down in this country, you've got to make it on getting the cost of capital down. And that's pretty realistic. And the way to get the cost down, he argues, is through tax policy that provides incentives for capital investment and for savings. And then he goes on to talk about regulations and things like that.

I'm writing him a little note that says, Willard, why didn't you say something about consumption? And why do you just -- why do you guys who have the ability to get into

"Business Week" and communicate with billions of people who own these big banks and these big companies and can communicate with millions of people, why don't you say something besides we ought to have a Tax Code that provides incentives for investment, saying that -- you've been saying that for a hundred years. What you now need to start saying is stop making that Tax Code pro-consumption, because that's the heart of the battle, that tax -- because there's another little article on the previous page for those who are going to go back and read "Business Week" now if you haven't, it says we're not saving any more. People are not saving in this country. And the reason that they aren't saving any more is that the psychological benefits for consumption are there right now, this sort of a window of opportunity when they found out that General Mills -- or General Motors would sell them money for 7.4 percent. Everybody went out and bought a car.

And there's sort of a feel that that's -- that's where people are going to be.

But we have had a whole generation of living with everything that fostered consumption in America, but it is particularly the income tax. It is just all pro-consumption. There's no question about it.

But until people like Willard and others in America say to all of us, we need to pull some of the rug

out from under consumption, you are never going to get appropriate recognition for savings and investment, because the money isn't there. The income tax, the individual income tax this year will raise $331 billion. That's one-third of all of our spending in this country, Federal spending. And corporate income tax makes a very puny contribution to the total. I guess this year it may be $58 billion. Last year it was $36 billion. It was nothing(?).

So you're not going to get incentives for saving and investment out of a Tax Code that is already so riddled with everything that -- and they're proving it over on the House side, and the President's proving it with (inaudible). Where are you going to get the money to lower the individual rate? The only place you get it is from a series of tax expenditures that were created to overcome high rates and a lot of other things. So that we would invest and we would say, and you can't (inaudible). You can't do any more against a lower rate.

So what I wish Willard would do and other people would do is argue for tax reform, but on the basis of some set of principles that would help us who have to write those tax laws decide what the country really needs. And I've just boiled those down to five simple principles, and I'll keep still.

The first is that if it's income tax reform

you're talking about, the first thing you have to recognize is something you already knew, and that's why we talk employee benefits, and that is that everyone uses their income to put a roof over their head, put food on the table, health care. You know, all the basic human needs have to come out of your income.

The question then is what will a tax on your income do to your selection of shelter and health and all the rest of these basic needs? I know they are important questions to ask, not a one of which is asked by Ronald Reagan or Jim Baker or any of the guys doing tax reform. That is not one of their principles.

They have a family principle in there, which we all argue about.

But it's all set out as a principle of income tax reform that the tax on income should in one way or another reflect society's values about the purchase of those basic needs.

The second principle is related to that. That's income security. Everybody ought to -- everybody works so they got something for a rainy day. That's the way it's been for as long as I can remember. I don't know where that term "rainy day" came, but you know what I mean. We put a little money aside or whatever.

Education -- well, education for our kids ought

to be up on the first category. But the income security helps. That one lacks over, because our children are our income security. At least they used to be. But you can look at that one either way. Education is very important. You've got to decide what in the world the income tax is going to do to eduction.

So the second thing, though, is savings, for disability, for retirement, whatever. And what we do then, in terms of taxing income, will determine whether people will save or not. 401Ks and KEOGHs, IRAs, Lord knows what else. They're just a mishmash today. They don't mean anything, except they're a convenient target for the President to attack, you know, this is some kind of a rip-off, let's get rid of them. Because he doesn't talk in terms of income and the fact of income as a principle that affects our income security.

The third is capital investment, and that is very, very important, particularly in a society like ours. But -- you know, I could give you examples of tax provisions that, you know, I just (inaudible) take you through the -- what's the current surpluses in commercial office buildings (inaudible)? How much money we're pouring away every year in commercial office buildings we don't need? Two years ago we broke the back of the barge industry in the -- particularly in the Mississippi River by putting everybody

into the barge business. We got all kinds of doctors that own barges now that they've never seen. We got too many barges that just sit there dying. You know, they're killing the healthy, kill the others. The year before that, I think it was railroad cars. Same old deal. Oh, but.

Butcher is absolutely right, I mean, when you put a tax on income, you ought to be cognizant of the impact it is going to have, however you structure it, on the willingness of people to earn money and then invest it in somebody else. That's the third principle.

The fourth principle is whether a Federal tax or a national tax ought to take into account the spending that comes out of the taxpayer's pocket at the State and local level. And since 1913 that has been an unspoken principle that the Federal Government is not -- is going to use the Federal income tax as a way to match State and local spending through State and local income, sales and property taxes. Until now. We decided that we're not going to do that anymore. We are going to get rid of the Federal match to the local -- the local tax.

That's an important principle. And it ought to be decided very explicitly, not in the terms the President's decided, which is the fat cats of New York are rippin' off everybody else, but do you want to us the income tax to match the property tax? If you were in the 50 percent tax

bracket in New York and you spent 50 cents or you spent a dollar on the property taxes to support education in New York, the Federal Government gives you 50 cents as the match. If you want to spend less in Texas, you get less of a match. That's sort of the way it's always worked.

So that is an important principle, if you're talking about taxing income, because it is only from income that you get the money to pay your local property taxes or your sales taxes or whatever. So that is important.

So the fifth one is consumption. And right now all the benies are with consumption. You get all the deductions for consumption. The casualty deduction and the medical deduction and the interest deduction and all of that sort of stuff just encourages you to consume. And we can do that, we can continue that process, or we can change it in some way.

But those are just five sort of principles that I think we could all agree, if the Ways and Means Committee and the Senate Finance Committee were faced with those five principles and everything they did, they had to measure against one of those standards, that you could participate much more readily in the process of tax reform, because you wouldn't be scared to death that someday we're going to come after employee fringe benefits, because you meet several criteria with that, these principal criteria. And if

society has made the commitment to shelter investments in education and in retirement and in health care, and you know, (inaudible), that's a societal commitment, and you got it with the employee benefits program.

But this -- there's no way now to get society to make a commitment, because those sort of things go to you (inaudible), you know, they're out to lower the rates at the expense of the (inaudible).

So I frankly hope we don't do that kind of tax reform. I don't know whether we will or we won't. I asked Bob, because I knew you would be interested, if he had talked to Rostenkowski lately, and he said he had last Thursday or Friday, and Danny, of course, is just really anxious to get a bill to us by the end of the month or early in November and can't quite understand why we are so blase about tax reform, because he's having a ball doing it, and this, we don't (inaudible), it's hard to believe that you can get this -- income tax rates in this country down to 35 percent and 33 percent by selective elimination of tax (inaudible). I can't get it through my head that it's possible. I can see where how we could get a flat rate tax of some kind in this country, but not the sort of (inaudible) that's being proposed. I have to guess today we aren't going to get tax reform, we won't have really meaningful tax reform until we, you know, come up with tax

reform based on some set of principles like that.

So in the meantime, though, we will -- we will have to deal with raising revenue at some point in time, and I assume that will come from minimum taxes, expansion of excise taxes which you can already see on the horizon, from that sort of thing. If it doesn't come from base broadening, it will come from some of those taxes (inaudible).

Well, let me stop at that point -- I have already talked beyond my -- whatever it was -- 15 minutes -- and respond to specific questions that you may have.

I will be glad to get as specific as you want to get or as I'm capable of getting. I thought I would scope it for you, so that you can explore anything you want.

QUESTION: -- in the consumption area, are there any studies or conclusions in programs out there that need support (inaudible)?

SENATOR DURENBERGER: Elimination of the interest deduction is one, if eliminated, takes it down to an investment income plus $5000. I mean, the principal holds in the investment income plus $5000. And I have made that proposal in 1982 and got shot down by the auto dealers and the yacht makers from Rhode Island and things like that. They thought it would impact on the sale of yachts and automobiles. But it is in the President's proposal right

now, and that, obviously, has some merit to it. We've already cut back on the casualty deduction. And on the health side, just gradually, I think, the changes that are taking place in system reform in this country will take some of the sort of surplus use of the system out already.

But I do have a proposal that sort of goes the other way. It argues that self-employed persons ought to have the same tax breaks as you and I have when we're employed by somebody else. So that it just sort of picks a maximum like 250 a month and permits the self-employed person to take a tax credit or a deduction, whichever way we structured it; I don't remember. Or 250 times 12, where if it's good for you-all, it ought to be good for him.

Well, that's not going to go anywhere, because we don't have the money in the Treasury to do it, but it illustrates the point that some of us are in Fat City on that -- on that particular deduction by comparison with those who have nothing, but the reality is, it isn't fair to characterize that as Fat City either, because that opportunity that you people now have to reform or help all of us reform the health care delivery system by leveraging the way you present health plans to your employees is the perfect opportunity, because if you didn't have it and you weren't taking advantage of it, a lot of companies can get -- change employee behavior. We wouldn't be able to turn the

system -- we couldn't turn it around just with Medicare. We've changed the reimbursement system with Medicare, and that was really important.

The things that you're doing to provide choice of health plans and to get people to be smarter buyers of health care and the wellness stuff and relate that to the sick care benefits. All that. Think, God, that's like having 150 million pupils out there. If you just educate them to the value of choice in health care, the benefit is bad only by comparison with the folks that don't have any benefits at all.

But the other thing, of course, is a national sales tax or value-added tax, something like that. The only thing we have -- we have two things out there now that you could look at. One is the manufacturer's excise tax on Superfund(?), and the other is Bill Roth's business transfer tax, and both of those are value-added taxes or a sales tax. In the case of value-added tax, another disguise, not very thinly disguised, but there they are, seen as sort of a start in the direction of a consumption tax. (Inaudible.)

If I could get any encouragement from large numbers of people, I'd go find a Democratic cosponsor and just put in a national sales tax bill and then try to push it along, but there is no point in doing that, because Ronald Reagan does not want any new taxes, and I'm up

reelection in 1988, so why should I be the champion of a new national sales tax, when we're not going to get it? If we could get it and use the money to reduce the payroll tax or use it for some specific tax reduction, spending reduction purposes and put it in place by '88, I would be glad to be the hero. I could get reelected like nothing, because the sales tax is an idea whose time has finally come, looked at as a national sales tax(?). But it has to be tied into the deficit one way or another, otherwise it won't work.

Yes.

QUESTION: Senator, you've been one of the leading proponents of encouraging employers to offer choices of health plans to their employees as a way of making employees more sensitive to the costs of health care. One of the provisions in the Treasury 2 versus of tax reform is a set of uniform nondiscrimination rules. As we read them, at least in the Treasury 2 version, would allow a plan to be considered nondiscriminatory only if all plans are available to all employees at the same contribution per employee, so that it would defeat the purpose of having choices of health plans. In other words, a high option, low option, would all depend -- a plan would be nondiscriminatory only all of those ---

SENATOR DURENBERGER: All employee contributions were the same?

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QUESTION: Only if the employee contribution was the same. How do you expect that to fare?

SENATOR DURENBERGER: Well, it might fare very well, I mean, because it looks like fairness or something like that. But the only doing we should do on the quality of contributions is on the employer's side. I think we ought to -- I mean, there's two things. There's an element of choice, but the employer's contribution ought to be the same to every single plan. That way the employer is not deciding for the employee which plan to go into.

Now the problem -- obviously, those of you who are familiar with the Twin Cities know one of the problems that was created out there when they adopted the notion of equal employer contributions. They took the highest price plan and said we will pay -- I mean, they took their own self-insured plan or something like that, which was very costly to Honeywell, as an example (inaudible). They were paying $225 a month to that plan and much less to some of the others. They said, "Well, our contribution will be $225 a month." Well, all these HMOs said, "A great way to make money. They're willing to give us $225 a month."

So it's how you -- how you do that one that is important. No, either I wasn't concentrating on it or didn't think tax reform was going to pass, but I now have -- Jim has to give me a note of that to remind me, because I

don't know when that tape will be typed up.

That is just the opposite of what they ought to be going about, which means that somebody on the health side of this administration didn't look at the -- and there are some decent people on the health side at Treasury, but they didn't look at that (inaudible).

Well, let me just mention -- well, I can mention that, in case somebody doesn't ask it, my views on mandated benefits, I know, may not be clear to all of you, but with the exception of mandating in exchange for the tax-free nature of this benefit, I think the mandates ought to be choice -- equal employer contribution with the right to buy as little or as much as you want, cash backs, all those kinds of things ought to be in there, but freedom of choice between the employer and the employee. Continuity, which we put on reconciliation this year, which you may not like, but it's on there. Eighteen months covers all circumstances, and the cost is 102 percent of the group premium.

Catastrophic, and we haven't agreed how to define catastrophic.

And I think the fifth one was -- and this isn't clear in my head yet whether we should or shouldn't do it, but a minimum package, so that everybody has to make a choice of something. That helps you avoid adverse selection in some cases and helps you with the situation where some

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people would say, well, I don't want any health care at all, and it just helps to keep contributions for your -- for your carrier, it keeps the contribution. I am not going to say whether that should be in there or not. But all the other mandated benefits -- you have to have chemical dependency. I guess Chafee's got it. You have to have preventive benefits. I am deadly opposed to all of mandated benefits. I know most of those are done on the State level.

That's the kind of thing you ought to work out with your employees, and where you want to get out ahead of the pack and do chemical dependency and mental health and some of those sort of things, you should do it, but you should then leverage the local marketplace and deliver a decent product. When you get those across-the-board mandates, you've got a lot of people delivering health care services that don't deliver a very good product.

(End Side 1.)

(Side 2.)

QUESTION: I'm not sure I fully understand that equal health care contributions will benefit all employees. I don't know exactly what you mean by that, because aren't we just taking out the free market system totally out of that part of compensation (inaudible) part of compensation?

SENATOR DURENBERGER: Unless you and I are on different tracks, the only think I was saying was that your

employees ought to know that you are willing to put in $200 a month for each of X number of health plans, or say, $400 a month to a cafeteria plan of a variety of benefits, and your contribution will be $400 regardless of what set of benefits they take, or it will be $200 regardless of whether you take an HMO or an Aetna plan or a Blue Cross plan or something else. Your contribution is $200. If they only want to buy $100 worth or $50 worth, then they ought to get the difference in cash or other benefits.

QUESTION: I guess the problem that I have (inaudible).

SENATOR DURENBERGER: Oh, yes, right.

QUESTION: Where does that leave us with negotiation? You can put plans in for salaried employees which may provide a certain number of benefits which are not negotiated, and you have to be operating under a pension (inaudible) plan somewhere else. And a union demands on there (inaudible) toward wages and benefits, are you in effect saying (inaudible) we have to have $200 toward the benefits whether or not the benefits cost $200 (inaudible)

SENATOR DURENBERGER: No, what you'd be saying is that the Federal law requires that we make -- if we are going to provide a health plan, and you are going to get that plan tax free to your employees, then we cannot contribute any more -- we have made a decision to keep it at

the $200 a month level, or we will negotiate countrywide. I don't know how you're going to set it up. If you're going to make decision that gives you a max, and within that maximum you can negotiate anything you want in different parts of the country if that is what you want to do. Just so that wherever you are, your contribution is the same to each health plan. It doesn't mean that your $200 is the level for everyplace in the country. It doesn't have to have them that way, because if in Huntsville you want to a $150 health plan, you can do a $150 health plan, and you can negotiate with the union for something else. You can also negotiate a $250 health plan in Huntsville if you want to do that, except that they will be taxed on -- hopefully, they will be taxed on everything over $200.

The only point I am making here -- we may not -- again, may not be on the right tax -- is that each of the plans has to carry the same employer contribution to them. So that you aren't saying, if you take the HMO, we will pay $200 a month. If you take the service plan, we'll pay $250 a month. That is the way it would work. Still missing something.

QUESTION: It sound dangerous, I think. I just note the differentiation by line of business, foreign competition. If we have to bring a plan up it's an added employer expense, how do we compete?

SENATOR DURENBERGER: Any way you want. I mean, you can give $500 a month for health insurance benefits. It's just that I'm not going to subsidize everything over --

QUESTION: (Inaudible.) I'm worried about being below the $200.

SENATOR DURENBERGER: What

QUESTION: I'm worried about being below $200 and being forced to bring it up to $200.

Oh, I see what you're getting at now.

SENATOR DURENBERGER: No, I don't think -- we wouldn't deal in dollar amounts. All the law would deal with in is equal contributions.

QUESTION: In a location.

SENATOR DURENBERGER: Pardon?

QUESTION: In a location.

SENATOR DURENBERGER: In a location or however you want to do it. Just for the person. And we're looking at it from the standpoint of the consumer. When your employee is buying, making that choice they ought to see an equal contribution for each of those plans. Now you're going to have one equal choice in Huntsville and another equal choice in New York City. That's fine. Just so from the standpoint of the employee, he doesn't see you telling him that one's the bargain, you know, because that's the one

we're going to put more money in (inaudible).

QUESTION: I think what's happening is -- I think I understand what you're saying. From our perspective, if it's 150 bucks and you get 50 bucks left over, 200 is the floor, you're going to take anything over 200, the family plan is -- we can provide a good family plan for 150 bucks to an individual in Texas, where the same plan may cost us $200 in New York City, what happens to that $50? What happens from the employer and employee standpoint in Texas? I think that's really what your question is. And why should we be obligated to do something with that $50? That is $50 that we could take and put into extra compensation. It could be put into other type of benefits, you know, et cetera, et cetera.

SENATOR DURENBERGER: Right.

QUESTION: You know. Et cetera, et cetera. That's really what his question is.

SENATOR DURENBERGER: Yes. And I hope I answered that part of it, that you can do anything with it you want. You can make the decision to do $200 all the way across the country, if you want to do that, or you can make the decision to do $200 here and $190 there and $180 there and $150 there or however you want to mix it. You can mix it in any way possible.

One of the things that is suggested by this line

of questioning though is, if you had a tax cap on the tax-free nature of the benefit in addition to an equal employer contribution and everything else, that cap would not have geographic exception to it. That cap would be the same across the country, and we're doing that simply because we don't believe there is any reason why they should us more in New York City than they should charge someplace else.

That defies -- if that defies the current record, because that's where we're going with DRGs and Medicare. The Mayo Clinic will hospitalize substnatially less and at one-third the price of the hospitals in New York City and Boston, I believe. And it's not because they're in Rochester. It's because they practice a conservative style of hospitalization. In New York City, they are wasting your money. In Boston, they are wasting your money. And you already know that, you just don't know the degree to which it exists.

So that's one of the reasons why the cap, as proposed, is so high, so that you can get the New York Cities and the Bostons and that sort of thing under it. But the way they are going to have to hit is downward. The rurals -- the Huntsville, Alabama, and all -- I don't know, perhaps Alabama in general is going to go up. They are going to make money in the rural communities and some of the southern States and so forth, and so forth, that have

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practiced conservative, they're going to do pretty well.

The high cost is because of the Southern Californias and the New Yorks and so forth, they are going to have to come down, and they are going to come down by not having four specialists, five specialists called in on every care. That's the sort of thing that they do to waste your money. Though on that particular issue, the regional differentials -- and if we do go to a cap, it would be the same problem, try to keep an eye on that (inaudible) doesn't (inaudible).

Most of the other things, you don't have regional distinctions on, even may it so-call cost less to live in Alabama than it costs to live in Minnesota, I think, you know, for retirement purposes and lots of other things, you pay an equivalent amount all over the country.

QUESTION: Senator, we have determined actuarily that we have about $280 million of unfunded liability in the health care area for retirees and those individuals who would be eligible for retirement if we terminated our plan, et cetera.

Is there any thought being given to some way that we could fund that on an as-we-go-basis as opposed to just always having that liability out there? We now have no ability to really fund trusts or anything of that nature for those retirees. I can tell you we have approximately 8000.

Going around the country and talking to those retirees, that is a big issue. They understand their pension is safe. They appreciate that. It is a sense of secure -- but when you're a widow out there, and maybe you're getting 250 bucks a month or something like that, and the company is paying for health care, it's a big threat, and you're concerned about it, and it's a very commonly asked question, and all you say is, I'm sorry, the Tax Code doesn't permit it. There's no way we can go about it.

SENATOR DURENBERGER: I don't know the answer to that. I guess I've heard it come up a number of times, so I know it's a real problem. I just don't have the internal capacity right now to come up with an answer. So if there is one, and it's just a matter of statutory change -- I know you don't like ERISA, nobody does, but maybe it's an amendment to ERISA or something like that, to permit some way within the Code provisions to fund that liability. Otherwise, you'll just have to be sort of patient, and as competitive medical plans catch on, you will have a situation which will take some of the fear out of the long-term problem, the current problem being is most of the people are going to live forever and get all their expenses in the last six months of life and all that sort of thing.

The reality is that as soon as the Medicare choice of medical plans gets expanded until you can really

see it work, then we will be able to change the way in which we buy health care for the elderly, so that we'll get out of the DRG business and all that sort of thing, and we will just pay an actuarily determined dollar amount to each of your retirees' health plan. They'll chose the health plan; we'll pay a dollar amount based on age, sex, average community cost of health care and their previous health condition. And you can do anything with that you want.

At that point most of you ought to reexamine the way you're doing the health care for retirees and see if you can't work out a match between what we are willing to pay for and what you're willing to pay for and what those employees are willing to pay for by way of cost sharing. So then they end up buying one plan, period. No supplemental, no wraparounds, none of that stuff. They just buy one plan. We put X dollars into it. You put X dollars into it, and they have some other cost sharing (inaudible). And then at that point, we can all start thinking about expanding Medicare benefits, trying to bring social insurance into that program, so you can get the social services in there that reduce the cost of medical service and things like that, but in the long term for a healthy company, I don't have any concern that any of those unfunded liabilities are going to be a problem for people, but I know we've all hit that line down.

I know we're now at the point where we're going to be able to do more creative things and enable you to do more creative things. So personally, I don't worry about the folks that sit out there with the $208 billion of unfunded liabilities, because I think the system reform is going to cure that, assuming it's a good company. But if it's a company that fails, I want to look (inaudible).

(Laughter.)

And if it's obviously a company that has problems, you know, we ought to consider your suggestion that -- I assume, that whoever said it should do it. But some way to enable you to cover those (inaudible). And if somebody will just be sure that I'm reminded again of -- maybe somebody here already has an idea in their tax (inaudible) someplace for handling that problem. I'd be glad to (inaudible).

Well, what happens is that the Tax Code does not any break to the company for funding those. You can't do it as a trust, that's basically with the Tax Code right now. If the Tax Code were amended, then you could go ahead and do something in that area (inaudible). Yes.

QUESTION: (Inaudible). The County Financial Standards Accounting Board is currently (inaudible) looking at making companies (inaudible), although we can't (inaudible). (Inaudible) health insurance or life

insurance. So we may have to (inaudible).

QUESTION: I think it's important to realize that many employers are putting a moratorium on the entire (inaudible) health and life insurance plan until we find out what the liabilities are going to be, because they are significant for some companies, a portion of what they --

SENATOR DURENBERGER: What does "moratorium" in that sense mean? Not expanding benefits or --

QUESTION: It goes from the (inaudible) if all of a sudden the question of retiree health becomes very important, the union realizes that they have a relatively week retiree health insurance plan, Medicare has been cutting back over the years, and there is a lot to fill in, and they want to provide a benefit to the retirees, the company takes a hard line and says we're not going to do that because we just don't know what the future (inaudible) is. We may say at the table that costs 10 cents and now we find out because of the funding requirements, that it's really 10 cents an hour. (?)

SENATOR DURENBERGER: Well, thank you all very much.

THE CHAIRMAN: Thank you very much, Senator.

SENATOR DURENBERGER: If you've got any ideas, let me know.

(Applause and end of tape.)

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(APPLAUSE)

MODERATOR: We wanted to share with you what is in store for you today, and we thought that might be a good way of doing it.

We don't ask for your time on a Saturday in October without trying to do our best to ensure that your time is well used and that we do a good job in presenting to you information and I hope some entertainment as well, and some fun today, as we consider the key issues that are confronting health care.

All of us are involved in that in one way or another. And so we wanted to have you here. This is the second time we've held this seminar for U.S. Health. You know that our organization is growing at an astonishing rate right here in Ohio, and outside Ohio as well, as you'll hear later on today.

We could not think of a better way to begin this important day for us than by having with us the most influential senator with respect to health care in the United States today.

I say that because, in his fifth year as chairman

of the Health Subcommittee of the United States Senate, he has already brought about some of the changes which we hear talked about in all the other seminars, publications, other ways in which we gather information about health care.

He was one of the people that was most instrumental in the adaptation, or the adoption, of the prospective payment system, the DRG system that Medicare has adopted, which has had such a spectacular effect on the way health care is delivered.

He is also an acknowledged Congressional leader in the health care financing reforms that are sweeping throughout the nation in areas other than just the prospective payments system.

So I'm really pleased, and we're very honored to have with us today, Senator Dave Durenberger.

Senator Durenberger.

(APPLAUSE)

STATEMENT OF DAVID DURENBERGER
UNITED STATES SENATOR FROM THE
STATE OF MINNESOTA

SENATOR DURENBERGER: Well, that's the best introduction I've had in a long time.

You can tell marketing has come to the hospital business -- sure hasn't come to the floor of the Senate. I didn't have my red tie on, I didn't know you were going to be stealing that clip. Didn't have my hair combed.

(LAUGHTER)

It's sure nice to be in Ohio -- It's nice to be anyplace but Washington, D.C. these days. It's particularly nice to be in Columbus around Columbus Day. I guess that's the appropriate place to be. You could be in Columbus, Indiana, or -- we don't have a "Columbus" in Minnesota.

But I am appreciative of the opportunity to get away from Washington. We haven't finished our session yet, as you probably know. It's one of those odd situations in which we just can't seem to quit. That doesn't seem to be a problem this year for John Glenn -- I wish it were.

(LAUGHTER)

But I have this tenuous majority. We're hanging on by only three votes, and all that sort of thing. And much as we love John and a few other Democrats, we're just

terribly anxious to stay in the majority so that we can do some of the good things we're doing.

This past week, I spent a lot of my time not in my health -- well, I spent a lot in the health capacity, because we've been in reconciliation. I'm going to talk to you a little bit about that. You'll find out how little money you're going to make in the coming year.

But I spent a lot of my time also in another capacity, which is chairman of the Senate Intelligence Committee. And in this audience -- a bright enough audience -- I suppose most of you people know what an oxymoron is: two words that are mutually inconsistent, like "Senate intelligence" --

(LAUGHTER)

And this was the week that a young fellow from Marinette, Wisconsin, who told his wife he was working for the CIA so that he could go down to Central America and peddle arms, got caught peddling arms, and a couple of his buddies got killed. And because the President was out of town, it became a big deal across the headlines.

And I've spent an awful lot of time in the last three days trying to explain that it's not the Central Intelligence Agency that is involved. But there is somebody involved in our government; we just don't know who.

And then, under my breath, I ask, you know, why

do we really care? Since the policy down there is so difficult to understand, to begin with. We are about to vote, or we have voted $100 million to fund direct help to the Contras, and I can't quite figure out why we are spending all of this front-page news and the front end of television trying to explore the origins of an airplane and these poor soldiers of fortune.

But that is only one of the many inconsistencies that face you in your business today. Five years ago, I would never have been invited to Columbus, Ohio to make this speech. Five years ago, I don't know that there was a U.S. Health, probably not. Jerry Vale was busy peddling insurance, and that sort of thing. And I don't know what Erie was doing; I suppose he was just a hospital administrator or something like that. But a lot of you folks weren't what you are today.

There was no Roberta Clark doing marketing, I suspect. Nobody was buying Charlie Garfield's book. Nobody was buying my books. Everybody writes books. I'm here on a stipendiary relationship, too, with the publisher. My publisher is "Piranha Press," if you can believe that --

(LAUGHTER)

Honest to God. It's a former Marine, who loved what I had written about national security policy, because I knew nothing about it when I went to the Senate in 1978.

Four quick years of education, and I wrote some white papers for my constituents, because they didn't understand it, either. And I was up for re-election. I was the first Republican to run in Minnesota in 30 years, for re-election.

And this former Marine saw this stuff I wrote, and he said, "Publish it." And I said, "You publish it." So he published it. Then he called his company "Piranha Press."

(LAUGHTER)

So now, I'm into health. But I'm trying to write a real book on health policy, so that these speeches would be shorter, but it's really hard to do. I mean, things are happening so quickly out here, and they're so hard to understand, that I can't get my book done.

So this is a book. But what this really is, is 44 speeches, that sort of frame up some of the things I'm going to say today, a lot of the things I can't say today, some of the things that you've said to me at various meetings around the country.

But to make it meaningful, it has to be put in some context. We can deal in today, and we can deal with all of the business about U.S. Health is going to try to capture the market in Columbus like it is capturing the market in Portsmouth, thinking that somehow or other this is going to bring some stability to the future of the hospital

industry.

I think it will not, and we'll talk about that maybe when we get to the Q-and-A.

But you're searching for some stability. You've got to put some meaning to long-range planning. Somewhere in this audience is the long-range planner for this organization. The poor person is going crazy, trying to figure out not what's going to happen five years from now, but what's going to happen next year.

He's probably in this audience because the senator was -- for the fee he's being paid, he promised to come and say, "What's in reconciliation?" You'll be the first audience in the nation to hear what's in the reconciliation bill, because -- man, that makes a big difference.

But does it really make a difference? Does it really make a difference?

Well, yes, it does make a difference, but only in the larger context of where we are going -- where we are in this country, where we've been, and where we're going.

Now, let me quickly try to put you in that context with the story of Sven and Olie, who are two Minnesota farmers. And Sven had this old, broken-down horse that he wanted to get rid of. He didn't want to kill it, he just wanted to get rid of it. So he went to Olie and he

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said, "Olie, would you take it off my hands?" And Olie said, "Oh, gosh," he said, "it's just too old, too decrepit. I've got horses of my own."

But Sven says, "I'll give you two dollars if you'll take the horse." He says, "Okay, I'll take the horse off your hands for two dollars."

So Sven goes home, and he's thinking about the poor horse for a whole day, and he's starting to miss the horse. So he goes back to Olie and he says, "Olie, I miss the horse." He says, "I've got to have it back. What do you want for it?" And Olie says, "Oh, ten dollars."

So he gives him ten dollars, takes his horse back. And Olie sits there and he says, "Now, why in the world did he do that?" He says, "Yesterday, he comes over with the horse and he wants to give it away; today, he comes and he buys it back for ten dollars."

So he said, "That horse, there must be something I don't know about the horse." So he goes over to Sven, and he says, "Sven, in 24 hours, you wouldn't believe it, but I've become attached to that horse. I'll give you fifty dollars for the horse."

Sven says, "Holy cow." He says, "Yesterday, I was going to give it away, today Olie wants to give me fifty dollars." So, "Take it," he says.

So Olie takes the horse, leaves his fifty dollars

behind. And Sven is sitting there saying, "Now, what did Olie discover about that horse in 24 hours? Must be something I don't know about." So he goes over to Olie and he says, "Olie," he says, "I can't stand being without the horse." He says, "I'll give you a hundred dollars."

So anyway, this goes on like this for the better part of a couple of weeks. And they got the horse up to ten thousand dollars.

(LAUGHTER)

And the word gets out around the county about this deal. And some other farmer -- when Sven's got the horse, the other farmer comes to Sven and he says, "Sven, I hear you've got this very valuable horse. I'll give you twelve thousand dollars for it." Sven says, "Sold." And so the farmer goes off with the horse.

And Olie comes over a couple of hours later and he says -- he goes through the routine. He says, "Sven, I miss the horse. I'll give you twelve thousand dollars for the horse." Sven says, "I'm sorry, Olie." He says, "It's too late." He says, "I just sold it to the guy on the other side of the county."

And Olie says, "No!" He said, "You didn't!" He said, "We were just starting to make a living off that horse!"

(LAUGHTER)

Well, I was born in 1934 -- which I know is hard to believe -- but I was born at a time when I was all my parents could afford to have. Right in the middle of the Depression. You don't know how incredibly tough things were in those days.

My parents' generation, who were the adults of the '30s -- Ronald Reagan's generation, also -- swore when they came to political power that their children -- me, a lot of you -- would never have to live through what they lived through.

And so when they came to political power after the Second World War, they created a system in America that made sure I would never be without. And they have succeeded. They have succeeded.

I was the beneficiary of the first free home -- or, I usually say, the five hundred dollar home, because a lot of people had to pay five hundred dollars for their homes. I was a veteran, so I didn't pay anything for my house. And in 1959 or 1960, I paid down my nothing, or my five hundred dollars, and I got a home that was -- I think the first house I bought was a $12,000 home. But I had 30 years to pay it off, at 4 percent interest, and all my interest was deductible, and the payments were so small, and the taxes were deductible, that there was nothing to it.

And all across America the word got out, just

like Sven and Olie's horse, the word got out, "Hey, you can have a free house." And all of a sudden, there were twice as many people with five hundred dollar bills wanting a free house than there were homes.

So what happened to the price of housing? Well, I sold my $12,000 home for $25,000 within a couple of years, bought a $30,000 home with nothing down, and sold that for $50,000. And today -- today, I have one home in McLean, Virginia that's worth about $350,000, $360,000, and I have a condominium in downtown Minneapolis that's worth about $65,000, all with a down payment of nothing, and 30 years to pay, all the interest was deductible.

We took the average price of housing in America from about 5 thousand dollars in the late '50s, early '60s, to 86 to 88 thousand dollars today.

Now, that's great. I've got the greatest savings account in the world. I've just told you, I have $415,000 worth of shelter. But, I've got a 23-year-old son, a 22-year-old son, a 21-year-old son, and a 19-year-old son, and when they get out of college they come back and live with me. Because they can't afford housing at $86,000 a year.

The same thing happened in health care. You all know it. We took a good thing, the employer-paid group health insurance, invited in Chicago by either Sears or Monkey-Ward, and one of these days I'll get it straight.

One or the other of them invented it, way back in 1904. And 50 years later, to celebrate what a great thing it was, we put it in the Internal Revenue Code, and we said, the company gets a deduction, and the employees don't pay taxes on it.

We then created first-dollar coverage. We destroyed insurance. We told Americans they could smoke and they'd get an artificial heart in case the smoking went wrong -- etcetera, etcetera, etcetera. We took the average price of a hospital room from almost nothing a day, to four or five hundred dollars.

We got a lot of good for it. We got fantastic medical technology. Now, when you're introduced, you have things like this. You've got lithotripters (Phonetic). You've got all these great things, for sick people. What have you got for healthy people?

Just like that. Health. But what have you got? Where are the rewards? Where's the rewards in the insurance system for staying healthy? Where are the actuarially determined life style rewards for staying healthy?

Why is it we still have sick leave instead of well leave in our companies? Why don't you give your employees choices of health plans that give them bennies for staying healthy, and penalize them in some way for getting sick or having an accident -- not penalize them, but at

least make -- take some --

Because you are my generation. Because you believe, like Sven and Olie, that you're really beginning to make something, when your house goes from $5,000 to $86,000.

So, I go through that only to put what we are doing together in a larger context. We're all in this together. It's a generational problem. My generation is the first that is about to leave it's children less well off. And I think you know that.

Today, the average worker at all of your hospitals pays 14.3 percent -- it's going to rise up to 15 percent here in another couple of years -- for the right to be part of the social security system. At $42,000 a year, that's a $6,000 contribution to a system that people under 35 don't even believe is going to be there for them when they retire. And on top of that, you have to put workers comp., and unemployment comp., and your health benefits, and everything else.

But think of it. Think of your children going to work, paying $6,000 a year, and in two years $8,000 a year, into a system that isn't going to be there for them -- at least, they believe it's not going to be there for them. And out of that system comes Medicare, and health care for the disabled, and your general social security cash benefit payments.

We can't pass an acid rain bill, because it costs too much. The President is going to veto "super fund" because it costs too much. We can't put enough money into elementary and secondary education in this country, because we've got a huge deficit.

Folks, that's the next generation. That's not me. I've got 15 years, and I've got guaranteed social security. I'm not going to get polluted. Those lakes are going to die from your Ohio smoke -- (Laughs) -- in my children's adulthood, not in mine.

That's the dimension in which we are currently living.

Now, that may sound like bad news, but I think it's good news. I think it's good news that most of us recognize what we are up to. And I think it's even better news that most of us recognize the causes.

We know the problem in the health care system today -- which appears to be cost -- is not the fault of the hospitals and the doctors. In this room, we know that. Out there, they don't know that. Out there, they think it's you that's the problem. Because, after they finish smoking two-and-a-half packs a year and get sick, the doctor's bill, the price of admission to the hospital, the price of admission to technology, is very, very high. And it's so high that unless you work for one of these big steel companies or auto

companies or somebody like that, with their very rich health benefits, it comes out of your pocket, or out of the welfare system, and it looks -- Wow!

But are you at fault? Of course not. Who is at fault? We all are.

I've already talked about the consumptive society, the notion that we can have without paying for it, the notion that we don't have to live within our means, and the notion that we do not have to take responsibility for our actions.

I talk about this a lot in the context of dollars and cents, but talk about it in the context of everyday life. Talk about it in the context that Bill Moyers took us to a few months ago on a Saturday evening, in a ghetto in Newark, New Jersey. Young and teenage and pre-teenage boys and girls, walking around the ghetto, jiving with their boxes, and talking about how much fun it is to play mommie and daddy, without having any responsibility.

You see, that's the ultimate problem for a generation that is misusing a gift from its parents.

My parents didn't intend that lack of responsibility. My parents didn't intend that I didn't pay my bills. My parents didn't intend acid rain, and a lack of investment in education. They didn't intend that. They only intended that I feel secure, that I have access to

health care, and shelter, and good education, and clean water and air. They intended all those good things.

But folks, it's out of hand. In this business, it's getting pulled back. It's getting pulled back. About the only place it's getting pulled back, the only place, in this business right here.

And how are we doing it? Largely, by dealing explicitly with our problems, facing them up-front, saying the notion that America can have a national health insurance system called a hospital isn't going to make it. Any more than you can have a national saving system called the home, you can't have a national health insurance system premised on the notion that everybody who walks through the front door of a hospital comes out the back door well, and the system can work on that basis. It cannot. It cannot.

It has not. Maybe it can in some other societies, I don't know. But it has not worked in America. So we're changing the system.

How are we changing the system? By changing the way we finance the system, very simply. Rather than letting you send us the bills and we pay for them, and "we," being the insurance companies, the Medicares, and so forth -- rather than having you send us the bills and we pay for them, rather than having people be able to have whatever they want, we're letting people decide what they're willing

to pay for, and we're only going to pay so much.

So the prospective payment system and Medicare is designed simply to say to you all that this is how much money you can make on this sent of procedures. Those of you who do well, can make money, and those of you who don't, should get in some other line of business.

That still isn't the ultimate. That's a transition. That's a stopping-off point to the place where there's a whole new set of buyers in this market. So we're moving in transition, by changing the way we finance the purchase of health care protection.

And it's not the same all over the country, but you can find the common elements in it, and they are very common elements. The elements are, mainly, take responsibility for your actions and your choices. Now, we're saying that to the hospitals and the docs: "We're only going to pay you so much. You're responsible for delivering the care."

In the process, we hope to get to the ultimate consumers and say, "You're only going to get so much." But you're going to have a choice, you're going to have a choice of health plans. You're going to have a choice to stay healthy, or get sick. And you're going to have a choice in that system of doctors and hospitals, and what-not. So that is the ultimate in consumer choice in health care.

But along the way to this ultimate, we are in the middle of prospective payment. And Medicare is a large part of the prospective payment system. We're not the only part, but we seem to be sort of the driving force right now. And so I have to tell you a little bit about the reconciliation bill, so that right away all the rumors you've heard, you can verify.

I first explain a small problem we have, that the House and the Senate are not the same. The House represents big cities, small constituencies, concentrated constituencies, constituencies easy to identify and poll. The Senate represents larger constituencies. They look more like the country, than like a little community. We're more rural-oriented than we are urban-oriented, for example. Or, at least we put equal shoes on equal feet.

The PPS -- HCFA, you know, determined that the PPS rate would be a half-a-percent increase for hospitals. This year, we have settled at 1.15 percent, which is a heck of a lot better than a half-a-percent, but it's way below 2.2 percent, which is what PROPAC (Phonetic) had recommended. So the rate adjustment for the coming year will be 1.15 percent.

We've also required HCFA to annually recalibrate the DRG weights, in order to incorporate medical advances and new technology into the weights' annual recalibration.

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We're also on our way to developing a severity of illness adjustment, which we would hope to have in effect next October.

On prompt payment, the settlement on prompt payment is to require that HCFA pay its uncontested or clean claims in 1987 within 30 days, in 1988 within 26, then within 25, then within 24, and then within 23 days.

We maintain the PIP payments for a disproportionate share of hospitals which have more than a 4.9 percent Medicare. That was a must, because Dan Rostenkowski is still the Congressman from Chicago. We also preserved PIP payments for the under-100-bed rural hospitals.

On the capital side, what happened? Relatively simple. HCFA decreed that we were going to pull the capital payments into the PPS payment in four years. You were going to come out at -- I think they recommended 5.9 or 6.9 percent of the DRG rate would be capital. They do it in four years.

I reacted to that with my fair capital payment bill, which said ten years and had an easier transition. The organized hospital industry in America descended on the Senate Finance Committee two days before mark-up of reconciliation, and destroyed our proposal. And so I went into reconciliation and said, "Tell you what we're going to

do, folks. You don't want reform on the capital side. We're going to give you just reductions in reimbursement."

So the net result in reconciliation was that your capital reimbursement on a cost base for fiscal '87 will be reduced by 3-1/2 percent. In 1988, using the '87 formula, it will be reduced by 7 percent. And in 1989, it will be reduced by 10 percent.

Now, I can't tolerate a 10 percent cut, and I suspect some of you can't, either. That gives you two years, in effect, to get your act together as a hospital industry, and try to decide what kind of reform, rather than this sort of arbitrary continuing to cut into your capital investment that has been going on to date.

On the tax bill, hospitals did very well. Tax-exempt bond provisions, most of which were my responsibility on the Senate side -- and I regret to say I lost a lot to Rostenkowski on the House side -- but hospitals did very well. They were exempt from the state volume caps. They were exempted from the $150 million per institution limitation on tax-exempt bonds outstanding. We provided a pooling financial arrangement for non-profit hospitals to issue pool tax-exempt bond financing. We provided for two advanced refundings for hospitals.

And so generally speaking, on the access to capital side I think we sure didn't hurt anybody. On the

reimbursement, we have work we need to do.

Physicians -- a whole another story. I've always believed that the physicians are the key to health care reform. Hospitals -- it may be better to say hospitals are the key, and the physicians are the door. Hospitals -- we went to the hospitals, because we knew the hospitals were eager to change the way they did business, and we knew that their interaction with the physicians would be good, rather than bad.

But the door to health care is the physician, or the nurse, or the medical professional. Those are the people I go to for my health care.

The Congress of the United States is insensitive to that fact. That is particularly true on the House side. And it isn't helped by the fact that the AMA is out to get Andy Jacobs from Indiana, who was the chairman of the health subcommittee, and now Pete Stark, who is the chairman of the health subcommittee. And Henry Waxman was never the doctors' friend, anyway. So when the Senators go in there trying to be the friends of the doctors -- Whew! You know, you're just going to get blown away.

Well, we didn't let ourselves get blow away this year. We lifted the freeze, but we couldn't get away from a cap of sorts on physician payments, because that was the price for the House giving up on mandatory assignment. And

mandatory assignment we just don't need in this business.

So what will happen is, in effect, that we're going to have a phase-out of the Part B freeze. We will allow all doctors at least a modest increase in both their Medicare payments and the amounts they charge beneficiaries. Doctors who have historically been conservative and charge less, will be allowed larger increases in their actual charges.

On January 1, '87, the prevailing charge levels will go up by the amount of the Medicare economic index. That is expected to be around 7 percent.

Thereafter, if a doctor's actual charges exceed 115 percent of the prevailing charges, then the doctor can raise his actual charges by only 1 percent. If the doctor's actual charges blow 115 percent of prevailing, he can increase his actual charge by the MEI plus 1 percent, or a total of 8 percent in 1987.

In cataract surgeries, we pulled HCFA down to a much more realistic, inherently reasonable process, in which we have reduced the prevailing charges for cataract surgery by only 10 percent. But it's the way that we accomplished it that I think will be pleasing to not only cataract surgeons, but other physicians who are caught in this de-hospitalization of a lot of these procedures.

The one battle that I consider lost -- and it was

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the last one, and I was left being the only one defending it -- was the issue of mandatory assignment for lab services performed in doctors' offices. I was the only one insisting that we not go to mandatory assignment for lab services performed in doctors' offices, because I figured those labs are different, and those services are different, than those performed in hospitals and in other laboratories.

But nobody agreed with me. And so in the end, Henry Waxman made that his bete noir, and he won on it.

So those are some of the key issues that are included in the reconciliation. You can't find a lot of positive policy in there, any more than you could find a lot of positive policy in the tax bill this year. But you can find us shaping the contours of this prospective payment system, as we move towards a capitated system. And so that's where we're headed.

When I'm asked what American health buying will look like ten years from now, I say, everybody in America will have a plastic card. They won't have a hospital, like we had in the old system, they'll have a plastic card.

In the old system, the hospital was the national health insurance system. I mean, everybody could get to a hospital. In the future, it'll be a plastic card. And the card will be their membership in a health plan of some kind. That's why, when I read this little hand-out that I got sent

here from "Modern Health Care," and the story about all the midwest not-for-profit systems diversifying and entering into the insurance field, I can understand why. Because they recognize that where we're going is consumer purchases of health plans.

Now, right now, 37 million people don't have any health care, because they don't have a plastic card. I've got a plastic card. It's right back in my pocket with all my other plastic cards. But 37 million Americans don't have that.

So we set up different systems for them: Medicaid, and medical assistance, and all that sort of thing. No need to do that. No need to do that. You can buy, in effect, the indigent into the same system that employers buy me and you into, and that Medicare is buying the elderly, or helping to buy the elderly and the disabled into. How we get there will differ over a period of time. How we pay for it will also differ, will also differ.

In Medicare, obviously, we're headed for a situation where the elderly, when they retire, have the same choice of health plans as they had when they were working. If you stay in Columbus and you work for U.S. Health, you ought to have the same choice of health plans. I didn't ask -- I suppose you've got some captive arrangement, where everybody uses your hospitals and your doctors, or something

like that. A lot of hospital systems do.

VOICE: We tried.

SENATOR DURENBERGER: Okay, you tried, that's very good.

But let's say you work for somebody else in this town. You've got to have a choice of health plans. And you ought to have that same choice when you retire, and you ought to be able to go back to the company. You go back there for the retirement club meetings and everything, go back to the company once a year during the open enrollment period, and you get the same choice of health plans.

And Medicare will pay a part of the premium of your choice. Depending on your age, sex, previous health condition, and the average community cost of health care, we'll make a premium payment. Then, your company can make a payment to it, also, rather than your company having to deal with Medicare secondary and all this sort of thing, the company can agree to pay a certain percentage of your choice, also.

Then you decide how much benefits you want to add to it, but you add it to only one plan. You don't go out and buy supplemental this and supplemental that. Our objective is to put all these old movie stars into politics, and not into selling rip-off insurance to the elderly --

(LAUGHTER)

I'm sorry, that's an unfair characterization.

(LAUGHTER)

But my parents fork out $78 a month, each, for insurance they don't need. And I can't get them out of it. So I need some help, and this is the way to do it, by one plan, and just -- you know, the same people can sell it, the same people can sell it, in the insurance industries, HMO's, whoever they are. They can sell the plans. We're not taking business away from anybody. I think we're creating business for people. The only people we're putting out of business are the old movie actors -- and they do have other businesses they can go into.

(LAUGHTER)

Now, the same thing should happen in the employment sector. And I'm getting too long. I've got to shut up, because we have to have a Q-and-A here, right?

What we modelled the capitated system on is the same model that we have in the employment sector; that I'll have a choice of plans. With the federal employees health benefits, I've got 22 choices of plans. That's too many. I ought to have at least three choices of plans in any community, maybe four, something like that.

But that choice of plans is the key. And then, my right to make a choice, and the financing arrangements, is key to that.

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Right now, we're not doing that in the employment sector very well. Employers in this country pay for about 70 percent of the access into the health care system for about 70 percent of the Americans. They're not doing a very good job of paying for it. They could be doing a much better job than they are, if they would approach it as logical buyers.

Let me premise just quickly what I say about the employers in this community and others by again giving you a little philosophy, which is -- and it relates to what I read in this thing here, about what you all are up to. And I'm just going to quote what you're up to, by way of reference.

Mr. Chaplin said that (Reading):

> "About 14 percent of area residents are enrolled in HMO's and pre-paid plans, but enrollment is expected to soar to 25 percent to 40 percent during the next three to five years --"

Oh, Steve Garlock said that.

And obviously, U.S. Health is out to get their place as big as possible in that market.

In Portsmouth, Ohio, about a hundred miles south of Columbus, U.S. Health owns two of the three hospitals in town, and is negotiating to affiliate or consolidate with a third.

Mr. Chaplin says (Reading):

"With all three Portsmouth hospitals connected with U.S. Health, the system would have a lock on the provider market, and an opportunity to launch an HMO, which makes great sense in our outlying areas."

Well, I wrote "antitrust" in there, but I didn't really mean that (Laughs) -- What I really meant was -- I'm going to think out-loud with those folks about what they are trying to do, and what they're trying to do is the same thing they tried to do when they run one hospital: deliver the highest possible quality service to as many people as possible, particularly those who can't get their service anywhere else. That's sort of the way I encapsulate a hospital mission.

But how we all go about this can present us with problems. How do I go about getting my car fixed? I have never had my car fixed. I go to take it in to be repaired all the time, but in my head I don't believe it's ever been repaired.

(LAUGHTER)

I don't know what American has ever found "Honest John." Why? Because I'm a lone buyer in a great, big market, and they got me. You know, they got me out there. I don't know enough about what I'm buying, so I've got to go

on reputation, or I've got to go on something else. And that's kind of the way it's been in the health care field.

I don't know about one hospital or another, one doctor or another. I've got to rely on somebody else to do it: see the Yellow pages, a friend, or the nearest -- whatever it is. But do I know I'm really getting quality health care? No.

So part of what's going on in America today through consumer financing and consumer buying is to identify a buyer for me. And who is that buyer going to be? I think it's going to be the health plan. That's why you're searching to get an HMO, because the HMO is the buyer between the consumer and the provider, and you want it to be your buyer that's coming to me to sell me the product.

Now, I don't mind that, as long as I've got a choice of a couple or three other buyers as well.

Now, how do I get that choice? How do I make sure, when the U.S. Health HMO comes into my place of employment to sell me this product, which is your wonderful hospital system and your home health services, and all the rest of the wonderful things that you're going to have or that you already have, that I'm getting quality care? I really don't.

Who can help me make that decision? Well, the same people that helped me make the decision about all my

other health insurance over the last 35 years, 30 years: my employer.

Do you think there's any employer in America today that is really looking at these health plans as they come into the work place, to determine whether they're buying the best doctors, the best hospital? Or, are they just buying price and second opinion surgery, and that sort of thing?

I think there's very few that are doing that. Very, very few that are doing that.

So my view is simply this: We need to upgrade the employer, who is the payer, as my access point into the buying system. We also obviously need to upgrade the buyers, but they're doing a pretty good job of that themselves. And all of that leverages in one way or another on the providers in all kinds of mysterious ways.

All of that is only to say that only the Lord knows where we're going to come out in the next year or so.

But I'm going to quickly end these parts of the comments. You're suffering from the fact that I've been so busy in Washington, I haven't made one of these speeches in a while. But there is so much to say about what is going on. And I've got to tell you honestly, I have such a need to learn from people in Columbus, Ohio, which is why I may be taking a little extra time to do this.

Where are we headed on hospital reimbursement? To a national average, on October 1st of next year. To another percentage adjustment. To a severity index. The PRO system will start doing quality, as well as some of the other things that they're doing.

My personal belief is that there is more quality in the health care delivery system today than there was three years ago. I believe that. I can't prove that, though. I believe that the elimination of unnecessary utilization of hospitals is a good thing.

I believe that what hospitals are bringing to America today, by way of more creative, innovative services, by not hospitalizing people if they don't have to be, by coming up with creative alternatives, is good quality health care.

And Sarah McClendon can stand up in front of the President, and complain about the quality in American hospitals, and I'll say "Baloney." Yes, there are some "quicker-sicker," you know, early discharges. But compared to the good things you're able to do -- now, we have to measure that. We need the measurements of that, so we can keep doing what we're doing, and we're asking the PRO's to add that to their work.

The rural -- I don't know how many of you are out in rural Ohio -- I feel this disparity between urban and

rural fairly deeply, particularly the disparities between fairly large hospitals in rural Ohio that are not in an SMSA, trying to compete with similar kinds of hospitals in a nearby SMSA who are stealing their business away from them, because they've got that urban advantage.

Medical Technology Innovation Act, we have to pass next year, so that we can continue the flow of innovation into the system. I've already said we need to do the realistic capital reform.

Medicare restructuring -- we must address catastrophic, we must put in a catastrophic for acute care. It's got to be in Medicare, absolutely, has to be there, either all out-of-pocket over 2,500, over 3,500, something. We have to have catastrophic in Medicare, then my folks will stop buying the $78-a-month plan, and they can use some of that $78 to buy additional coverage that they may well need.

We have to include the chronically ill in Medicare. We can't keep dumping the alzheimers and all those people on the state Medicaid systems. It's not fair. The state of Ohio is having a tough enough time raising money for the non-elderly, non-chronically ill, poor, as it is.

If your state is like mine, 75 percent of the increased Medicaid money is going into nursing homes for the elderly or the chronically ill. It's not going to mothers

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and children, and the non-elderly poor.

Part A and Part B should be combined. There should be an annual deductible for both. There ought to be an annual, or a monthly premium that is realistic, and that is means-tested. A premium that is means-tested for Medicare.

There should be fully-paid prevention benefits, and partially-paid or cost-shared accident or illness benefits. There should be realistic mental health and chemical dependency treatment benefits in Medicare.

We sit on the floor of the Senate, and we're fighting, you know, the drug dealers, when our communities are full of problems we can't afford to deal with because we have such an unrealistic approach to chemical dependency treatment, benefits, in our insurance plan, including Medicare. The same is true of psychiatric and mental health.

In Medicare, next year is the year of welfare reform. But there are other things we can do. Risk pools, I didn't check to see whether Ohio had a risk pool, but risk pools are an important part of it.

I've talked to you about the role of the employer, as well. And I'll just leave you with the ultimate in the employer, the change in the employer side, which is that we convert the fully-paid premium, or the non-

taxed premium that the employer currently pays for us -- that we convert that to income to the employees, but give every person in America the right to deduct their insurance premiums from their taxable income.

The self-employed, the unemployed, everybody who buys a health insurance premium ought to get a deduction. But in order to pay for that, we are required, or would be required to in effect make taxable the current fringe benefit treatment.

I'm going to quit right there. And Erie, I'd be happy to -- Have I got any time left? I've used up all my time? Okay.

I regret that. But I'm going to stick around and talk to somebody informally in the back of the room. But I thank you all very much for the opportunity to be here, and I thank you for what you're doing out there. We desperately -- we need you a lot more than we need politicians these days, and I'm glad you're where you are.

Thank you very much.

(APPLAUSE)

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KEYNOTE ADDRESS

Senator David Durenberger

Chairman
Senate Subcommittee on Toxic Substances
and Environmental Oversight
Committee on Environment and Public Works

It's a pleasure for me to be here. I owe a special thanks to your president, Sam Dixon for appearing at our hearing on the Safe Drinking Water Act. I know I speak for the Chairman, Senator Bob Stafford and the other members of the Committee when I say that we deeply appreciate your support as an organization and as individual members, for the speedy reauthorization of the Safe Drinking Water Act.

I'm going to talk about water issues, but the larger driving force in Washington today, of course, is the deficit and how to deal with the budget. I happen to believe that the budget deficit is not a checkbook issue. I believe that sunk in in November of 1981 when as a member of the Finance Committee, I participated in cutting tax rates by 25 percent, indexing them, and reducing the marginal rate on the income tax from 70 to 50 percent. We cut spending by approximately $41 billion and nothing happened.

The economy just sat there, in fact, it got worse. The closer my 1982 election got, the worse the economy got. I woke up in November of '81 and said, "hell, you are not going to balance the budget, you are not going to get discipline in this system, you are not going to change the way we do things in this country by pretending this whole budget deal is just a matter of cutting spending, and taxes." The only way you're going to reduce the deficit is by redefining spending and defining it in the larger context of how we as a society make decisions about the utilization of resources. Whether it is tax revenues or capital or something else in our society, how we utilize those resources will answer the deficit question.

If we are going to go into the economic protection game and raise the price of automobiles in this country by $16 billion in order to save a few jobs in Detroit, well, that is one form of spending. If we are going to freeze the direct spending because it's all fraud, waste and abuse but we're going to let people in the business community write off the three martini lunch and anything you want to buy under the interest deduction, you'll never balance the budget.

What we are going to talk about today is a form of more appropriate utilization of our national and natural resources. I think you and I in one way or another are trying to find a more appropriate way to utilize our resources.

We start with the Safe Drinking Water law. You want speedy reauthorization, so do I. Yesterday was the only day of hearings that we intend to have so it's a good thing you were there. We're going to go to mark-up on the Safe Drinking Water Act shortly after Easter. Bob Dole has tentatively assigned us

a week of floor time in mid-May. We are hopeful that the reauthorization of the Safe Drinking Water Act can be through the full Senate before we recess for Memorial Day.

I don't mean to suggest that all the controversy has been resolved. As you know, the principal thrust of S. 124 is to establish deadlines for the standard-setting process at EPA. The amendments are designed to force action in a law which is seven years old but which has had little practical effect because EPA has largely failed to fulfill its mission.

Although there are few MCLs at this time, EPA has published in the Federal Register two lists containing 73 contaminants. The bill would require the Administrator to write an MCL for each within three years. This section of the bill caused a great deal of difficulty last year. On the Senate side, we tried to give the Administrator an option not to regulate a particular contaminant on the list of 73 if down the road new information made it clear that there was no threat to health. On the House side, the safety valve became the so-called rational basis language. EPA became fearful that we were setting an impossible precedent for regulation for this area as well as in other areas. So we didn't get the bill through the Senate because people couldn't agree on the design of the safety valve.

This year I was hoping to resolve the issue by just abolishing the safety valve altogether. We would find a list that the Administrator is sure he wants to regulate and tell him to go regulate it. No version of the rational basis test would be necessary. That is a sound approach if we believe that Congress can be ever-vigilant, scientifically dispassionate, if you will, in producing lists. But of course, Congress can't. That is not an appropriate role for the Congress when a program is not working well.

The Agency ought to be producing the list of contaminants in a timely way. But as I listened to the testimony yesterday, I was very troubled. I had Jack Ravan take the Subcommittee through the history of EDB. I used EDB because I presume there is broad public knowledge of the substance. EDB is a pesticide injected into the soil to kill nematodes and it's also one part per thousand of all the leaded gas sold in the country. So there are several hundred thousand underground storage tanks out there that are filled with EDB.

The government was first warned that EDB was a carcinogen in 1975. Good science was in by 1977; the action forcing documents in the Pesticide Office were prepared three times from 1979 to 1980. If you read those documents, and I have, there is no doubt that EDB is one of the most potent cancer causing agents around. None of the rats or mice survived at inhalation standards then enforced by OSHA. Not massive doses, but federal standards killed 50 out of 50 of the rats and mice.

In 1983, Florida forced the EPA to act when it discovered EDB in its drinking water supply. EPA suggested that Florida shut down the drinking water wells and the State Health Department took the extra measure of pulling the muffin mixes off the supermarket shelves.

EPA banned EDB first as a soil fumigant and later as a pesticide used on grains and citrus fruits. But where is the Drinking Water Office in all of this? It was drinking water contamination that alerted the nation, but EPA has yet to propose an RMCL for EDB. At best, it won't be proposing an MCL

until mid-1986 which will become effective in 1987. That means you will all have to start monitoring for EDB about three years after the other offices at the Agency banned the use of the chemical on food.

Woeful is too kind a word to describe that kind of a record. So we may get our list of 73 and a deadline for national standards, but I'm going to remain troubled because there is nothing in these amendments which solves the problem that made the list a necessity in the first place.

The other major issue that prevented reauthorization at the end of the 98th Congress was groundwater protection. The Senate bill does contain amendments to the Underground Injection Control Program which are designed to increase protection of the drinking water supply and also contains a critical aquifer demonstration program designed to build on the concept of sole source aquifers which is already in the law. But the Senate bill did not contain any omnibus or general groundwater protection provisions and we will continue to resist such amendments this year because all they will do is slow down reauthorization of the Safe Drinking Water Act. But we are not going to ignore groundwater. That would not be possible even if we tried because there has been a burst of concern for groundwater protection all across this nation.

In October of last year, the Office of Technology Assessment issued a two-volume report calling for a national groundwater policy. In November, the President signed a bill authorizing a National Groundwater Commission; the Energy and Environment Study Institute, born of an informal congressional caucus has formed a study group. The National Water Alliance has a task force which includes members of your Association. Bruce Babit, the Governor of Arizona and the Conservation Foundation have formed their own group outside the Washington Beltway.

Groundwater is getting attention everywhere you look but we're not going to let it slow down the Safe Drinking Water Act Amendments. We'll put groundwater on its own track, hopefully a fast track, but independent of S. 124, the Safe Drinking Water Act Amendments of 1985. Shortly after the Easter recess, the Subcommittee will begin oversight hearings on the groundwater contamination problem. We want to look at the Office of Technology Assessment (OTA) report, EPA's strategy, the various protection programs designed by the States, specific sources of contamination, including septic tanks, soluble pesticides, sanitary landfills, and underground injection.

We may have a hearing or two on specific contaminants: for instance, TCE, an industrial solvent is, I believe, the most frequently reported groundwater contaminant. I think we ought to know more about TCE, who makes it and for what purposes. We need to find out how it's stored, how it's sold, its fate and what fate does it have for those of us who drink it everyday. As the hearings progress through April and May I'll begin to develop the outlines of an omnibus bill which will be shared with all of you. We will use the task force of the National Water Alliance and other networks to test the concepts.

For this morning, I have put down a few thoughts on groundwater protection that I hope will get discussion started as you all go back home and think about your future involvement in the groundwater protection area.

Why do we need a national groundwater protection policy written into federal law? Let me give you five quick reasons. First, groundwater is the drinking

water resource for more than 50 percent of our population, or approximately 117 million Americans. Unlike surface waters in which pollutants are thoroughly dispersed and which are treated before consumption, groundwater can contain very high concentrations of contaminants because it is used directly. So it can be a significant public health risk when contaminated.

Secondly, groundwater is not adequately protected by current law. In fact, current law works to make it the dump of choice. We apply BAT to surface waters and doubleliners for land resources. The progression of our pollution laws has made underground injection, for instance, the principal disposal technology for hazardous waste. Third, EPA has a strategy and the states are beginning to develop protection programs but it is apparent that some of the fundamentals are not yet agreed upon.

I don't think that we should build our groundwater protection program on water quality standards, as we did in the first round of protecting surface water, nor do I think we should begin classifying aquifers as is proposed in the EPA strategy. I think Congress owes it to EPA, the states and to the public to provide some guidance on these kinds of questions.

Fourth, I think it would be cheaper to have a groundwater protection policy. Compared to clean-up, the prevention of contamination is a low cost technology. The average Superfund site now costs $6 million for clean-up and the cost is rising. In some places they're planning to pump groundwater through carbon filters for 30 years to achieve an acceptable level of restoration. Fifth, groundwater is a non-renewable resource. When one generation contaminates groundwater through carelessness, it is essentially contaminated for all time. The government must represent the interests of my children and your children in the conservation of this resource.

What should a federal groundwater law look like? It should be a prevention law but what does "prevention" mean? It means that the program should not sanction contamination by providing permits for intentional pollution like we do under the Air and Surface Water laws. Others may think that the purpose of a national groundwater policy is to choose which aquifers we will ruin. I do not. We will need a broad definition of beneficial waters that we intend to protect, not just sole source aquifers, not just drinking water aquifers or potential drinking water aquifers. Rather, we should define beneficial water -- the resource to be protected. We should define it perhaps as all groundwater supplies which are not already contaminated by natural elements beyond a level consistent with any possible use. The Underground Injection Control Program contains a definition which we could begin with. The UIC program defines beneficial waters as those waters which have less than 10,000 parts per million of total dissolved solids.

The groundwater protection bill could contain many elements basic to all environmental statutes: a partnership with the states supported by federal grants: an authorization for research and development of groundwater protection issues and technology: perhaps a codification of the new groundwater organizational structure at EPA with encouragement that other federal agencies with groundwater responsibilities like the geological survey work with EPA in some regular way. But these are the bells and the whistles, they are not the engine of a groundwater protection law. I think the engine was best defined in the recent report prepared by OTA identified three necessary elements in a national groundwater policy: detection: correction:

and prevention. That's a good start and I'm going to finish here by spending just a few moments with a thought on each.

Detection. It would not be appropriate, in my opinion, to set up a national groundwater monitoring network like we have for air and surface water. You can't learn much about the resource with that kind of monitoring. The wells you would need would be very expensive and add to the risk of contamination if not properly maintained. Therefore, I don't think we need a national resource assessment, nor can we get a picture of the quality of each aquifer.

What we can do is a much better job of monitoring the quality of the water we already withdraw. That will, in part, be accomplished by the amendments to the Safe Drinking Water Act which require monitoring of unregulated contaminants. In addition, we can go to sources of potential contamination which present a large risk like landfills, surface impoundments, tank farms and so on. We can do a much better job of monitoring for contamination in the immediate vicinity of these sources. Despite the many groundwater monitoring requirements that are now attached to RCRA, I for one, think we still have a long way to go on this whole issue of groundwater monitoring.

Correction. In most cases, correction is very, very expensive. It's often much cheaper to go down the road and drill a new well field. What approach would be taken in a groundwater law? Would we add a correction authority over and above that which already exists in Superfund, and if we do, how clean is clean? Who pays for the maintenance? What are the liability standards? I have not come to any firm conclusions on the correction piece of this puzzle. However, I will say that if contamination is detected, if it appears that contamination is spreading through an aquifer, then an adequate groundwater law would assure that steps were taken to prevent further contamination.

Prevention. There are two models for the prevention program. One model would look a lot like the Non-Point Source Pollution Program put together in 1983 for the Clean Water Act. Under this type of model, states would identify land areas that are particularly important for the recharge of an aquifer and identify the potential sources of contamination. States would write a management plan for reducing the risk in these areas. These activities would be supported by grants from the federal government.

The other prevention model is the RCRA model which was modified somewhat for leaking underground storage tanks. Under this type of model, you identify a source of contamination like landfills or tanks. EPA writes the technology standards for that kind of a source: and states run a permit program, or regulatory program, to assure that each source of that type is in compliance with the EPA technology standards. The state regulatory program is supported by federal grants.

I think the best groundwater law might be a blend of these two approaches combining the traditional land use authority of the states and the traditional standard-setting responsibility of the federal government.

We would build a regulatory ladder. States would define various critical management areas. In these critical areas, the most intensive federal technology standards could apply. You would have to use the best available technology. You would be required to do groundwater monitoring. There might be an outright ban on some activities. In less sensitive areas the regulatory

regime would be less stringent. In management areas, the only regulation would be protective performance standards.

On the federal side we create various standards for the technology. On the state side, land use regulation identifies the places where regulation is applied. The states would be pulling the regulatory trigger through their designation process. That is the kind of engine that I would have in mind for a groundwater bill.

Let me conclude by mentioning one final issue which will give some of you the chills -- groundwater quantities. I would probably be best advised to stay away from the quantity issue altogether since it's so sensitive in some parts of the country. Over use of groundwater resources will surely degrade the quality. I do not envision a federal role in allocating groundwater supplies among users, but in the Sporhase and the El Paso decisions, the federal courts have assumed such powers to be residual in the Commerce clause.

Perhaps the Congress and the states could work out a new compromise which would leave the authority to allocate the use of the groundwater resources entirely to the states with the understanding that such allocations will take into account the impact of water withdrawals on water quality. Congress may even provide considerable federal support for groundwater recharge programs as a part of this compromise.

These are some of my initial thoughts on groundwater protection. It is the first time that I have outlined my thoughts in public on the subject and I am pleased that I had this occasion and this particular group of people to discuss these issues with.

I'm looking forward to working with all of you as we did on the drinking water amendments, to continue to improve the high quality water that we are jointly responsible for delivering to the American public.

Thank you very much.

QUERY: Senator, I'm Duane Georgeson from Los Angeles. The City of Los Angeles has a groundwater basin contaminated with TCE and we're in the process of trying to get it cleaned up. We also have a filtration plant under construction for $150 million so you see we have a variety of demands on the finances available. Out of that concern for finances we're concerned with the section in your bill that deals with the identification of GAC as an available technology, taking cost into consideration.

Let me tell you where the concern comes from. It deals with the fact that you've identified GAC as a technology to deal with SOCs -- synthetic organic chemicals. The most prevalent SOC in our drinking water is THM. To get a 90 percent reduction in THM, the average water system in the United States would approximately double their water bills.

If you aim for something substantially less than 90 percent, like 20 or 30 percent, the cost probably is affordable. However, if you're trying to get down to a very low level of THM approaching a risk level of one in a million, you're talking about a cost which I don't believe any of us would feel is affordable.

I think there is a need in either the Committee report or the bill itself to deal with this uncertainty.

SENATOR DURENBERGER: Your concern was reflected in some of the testimony we heard yesterday and last year at public hearings on SDWA reauthorization. I don't know that we have a resolution to it but you can count that I'm not going out the back door on this issue. We'll work something out.

QUERY: Do you think we should be searching to develop a risk level which is uniform for all contaminants, and if so, what do you see that risk level turning out to be?

SENATOR DURENBERGER: I don't think so. I can share with you some thoughts on the subject that I've been sort of kicking around in one way or the other.

I would be much more interested in your reaction to that sort of thing. Maybe we can share some general observations on it with all of you and ask you to give us some thoughts on it.

Council of Medical Specialty Societies
Invitational Conference on

FINANCING GRADUATE MEDICAL EDUCATION IN AN ERA OF COST CONTAINMENT

April 11-12, 1985

L'Enfant Plaza Hotel
Washington, DC

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PROGRAM

Council of Medical Specialty Societies Invitational Conference on
FINANCING GRADUATE MEDICAL EDUCATION IN AN ERA OF COST CONTAINMENT
April 11-12, 1985 • Washington, D.C.

THURSDAY, APRIL 11, 1985

8:30 am — REGISTRATION — *Outside Ballroom A-B*

8:50 am — WELCOME — *Ballroom A-B*
OLGA JONASSON, M.D.
President, CMSS

I. BACKGROUND

9:00 am — **A. THE ERA OF COST CONTAINMENT**
ROBERT A. DERZON
Vice President, Lewin and Associates, Inc.
Questions and Answers

9:45 am — **B. EFFECTS OF COST CONTAINMENT ON GRADUATE MEDICAL EDUCATION**
RICHARD J. REITEMEIER, M.D.
Professor of Medicine, Mayo Clinic
Questions and Answers

10:30 am — Coffee — *Outside Ballroom A-B*

II. ANALYSIS

11:00 am — **A. ROLE OF THE TEACHING HOSPITAL**
JAMES W. BARTLETT, M.D.
Professor of Psychiatry and Health Services
University of Rochester School of Medicine, N.Y.
Questions and Answers

11:45 am — **B. RESEARCH INTO IDENTIFICATION OF COSTS OF GRADUATE MEDICAL EDUCATION**
GERARD F. ANDERSON, PH.D.
Associate Director, Center for Hospital Finance and Management, Johns Hopkins Medical Institutions
Questions and Answers

12:30 pm — Luncheon — *Monet*

III. PANEL: CHALLENGES TO TRADITIONAL WAYS OF FINANCING GRADUATE MEDICAL EDUCATION — *Ballroom A-B*

1:30 pm — **A. A PERSPECTIVE OF THE U.S. CONGRESS**
THE HONORABLE DAVID DURENBERGER
Chairman, Subcommittee on Health, Committee on Finance, United States Senate

2:00 pm — **B. PERSPECTIVE OF A STATE GOVERNMENT**
DELEGATE MARILYN GOLDWATER, R.N.
Deputy Majority Whip, Maryland General Assembly

2:25 pm — **C. A PERSPECTIVE OF THE BUSINESS COMMUNITY**
KARL D. BAYS
Chairman and Chief Executive Officer
American Hospital Supply Corporation

2:50 pm — **D. A PERSPECTIVE OF THE INSURANCE INDUSTRY**
LOUIS A. ORSINI
Vice President, Consumer and Professional Relations Division, Health Insurance Association of America

3:15 pm — Coffee — *Outside Ballroom A-B*

IV. PANEL *(continued)*: TWO RESPONSES TO THE CHALLENGES

3:40 pm — **A.** ROBERT G. PETERSDORF, M.D.
Vice Chancellor for Health Sciences and Dean, School of Medicine, University of California at San Diego

4:00 pm — **B.** MARY MCGRANE
Legislative Assistant to Senator Dan Quayle, Chairman, Labor Subcommittee on Employment and Productivity

4:10 pm — **PANEL AND PLENARY DISCUSSION**
MODERATOR: ROBERT G. PETERSDORF, M.D.

5:00 pm — Reception — *Monet*

FRIDAY, APRIL 12, 1985

7:15 am — **Breakfast** — *Monet*

8:30 am — **I. IDENTIFICATION OF ESSENTIAL ELEMENTS OF GRADUATE MEDICAL EDUCATION** — *Ballroom A-B*
ROBERT M. HEYSSEL, M.D.
President, The Johns Hopkins Hospital

9:00 am — **II. WORKSHOPS: PROVIDING AND FINANCING ESSENTIAL ELEMENTS OF GRADUATE MEDICAL EDUCATION**

A. Workshop I – Medical Training — *LaSalle Room*
Co-chairs:
JEROME GROSSMAN, M.D.
Program Director, Commonwealth Fund Study
FRANK RIDDICK, M.D.
Chairman, Council on Medical Education, AMA

B. Workshop II – Patient Care — *Lafayette Room*
Co-chairs:
WILLIAM K. HAMILTON, M.D.
Associate Dean, University of California School of Medicine
C. THOMAS SMITH
President, Yale-New Haven Hospital

C. Workshop III – Research and Innovation — *Montcalm Room*
Co-chairs:
WILLIAM F. DONALDSON, M.D.
Clinical Professor of Orthopaedic Surgery, University of Pittsburgh School of Medicine
DENNIS S. O'LEARY, M.D.
Dean for Clinical Affairs, George Washington University

D. Workshop IV – Unreimbursed and Underreimbursed Care — *Marquette Room*
Co-chairs:
JO IVEY BOUFFORD, M.D.
Vice President for Medicine and Professional Affairs, New York City Health and Hospital Corporation
SPENCER FOREMAN, M.D.
President, Sinai Hospital of Baltimore

10:30 am — **Coffee** — *Outside Ballroom A-B*

III. SYNTHESIS: POSITIVE APPROACHES TOWARD PRESERVING ESSENTIAL FUNCTIONS OF GRADUATE MEDICAL EDUCATION — *Ballroom A-B*

11:00 am — **A. WORKSHOP REPORTS**
Workshop I
Workshop II
Workshop III
Workshop IV

11:40 am — **B. PLENARY DISCUSSION**
MODERATOR: RICHARD S. WILBUR, M.D.
Executive Vice President, CMSS

12:00 pm — **Adjournment**

A PERSPECTIVE OF THE U.S. CONGRESS

The Honorable David Durenberger
Chairman, Subcommittee on Health,
Committee on Finance,
United States Senate

Incredible things are happening in health policy. Incredible things. They're all happening out there now without anybody having any control over it. Certainly, no politician has any control over it. But it's happening. It wouldn't have happened five years ago anymore than five years ago would you have seen a 24-year-old father in Massachusetts charged with vehicular homicide in the death of a three-year-old son not strapped in a seat belt. Five years ago you wouldn't have seen this panic to write living wills. Five years ago you would not have seen the Gallup Poll show that 81% of the people in the country agree with the New Jersey Supreme Court decision recently that says we ought to be able to pull the plug on competent as well as incompetent people. It wouldn't have happened five years ago.

Five years ago, we were sort of settling into the free lunch. We worried about the cost of health care, but we hadn't any idea of how we were going to deal with it. Some of us thought we did, but none of us could have predicted five years ago what health care delivery looks like today--not even experts like Alain Enthoven. He wrote the first book on consumer choice, but not even Alain Enthoven could have predicted what's happening. And there is no way that I can stand up here just on the basis of my election certificate and my knowledge of the subject and predict what's going to happen next year, the year after, or the year after that. It's very, very difficult.

Now, I am going to try to say a few things at the end of these comments about graduate medical education, and if this is a typical group, you are more susceptible to listening now than you were a year ago. Two years ago, you would have thrown me out of the room the minute I got into the subject. I very well remember some of those early meetings. I had an unfortunate

meeting up in Baltimore about a year and a half ago. I came late to a dinner meeting, because of what was going on on the floor of the Senate. They had already had an extra hour at the reception and we all sat down to a big dinner. I got on about 9:30 in the evening and I could tell I had half the room asleep and the other half mad. That was a year and a half ago. Now at least folks stay awake.

And I have learned a lot going around the country, to Chicago, Los Angeles, the Twin Cities--listening to people react to various aspects of health policy.

I just came back from two days in southwestern Minnesota. In southwestern Minnesota, in towns like Hutchinson, Montevideo, Granite Falls, Pipestone, Luverne, Slayton, St. James and Mankato, 15 years ago farm land was $200 an acre and three years ago it was $3500 an acre. Today, it's down around $1200 an acre, and everybody is slowly going bankrupt. These are the first victims of the generosity that my parents visited on my generation because they didn't want me to have to live through the things they lived through in the Depression. They created, in the post-World War II period, what you can characterize as the "have" generation. I am the "have" generation. I have to have today and send the bill on to somebody else. The economist Lester Thurow calls it the consumption society.

The "Have" Generation

We structured ourselves in America to have. My parents wanted, because they had so much difficulty getting it for themselves, me, after I married, to have a three-bedroom home with a recreation room and, at least in our case in Minnesota, two fireplaces, and have it in the suburbs where we were away from all of the problems of the city, and have it with maybe an acre of land around it, and so forth. And in order to give it to us, they had to create easy money, and so they made it possible for me to have a house for $500 down, 30 years to pay at 4-1/2%, interest, and the mortgage deduction that permitted me to send the cost of my home off to somebody else.

So people like me obviously said that is a very good deal. And so we said, "I'll have one." And more people said "I want one" than there were houses available, so obviously the price started going up. You all know what we did during that 15, 20-year period of time. We were smart. We started with your basic $10,000 home, which in a couple of years became a $20,000 home, even without a coat of paint. So we could put $9,000 in our pocket after a couple of years, take a thousand dollars and go buy another home. And we'd sit in that house for two or three years and make $40,000 on that, put $20,000 in our pocket, put a thousand dollars down and go into another home. We all did that. Farmers did the same thing, but for slightly

different reasons. They were told by the government to save us from the big trade deficit that came with the cartelization of oil, so they were told to plant, plant, plant, farm, farm, farm, and they were given the Production Credit Association and all those sorts of things in order to get that job done.

We all lived through that particular period of time in the history of our country. And we found that tax law responded to that, and banking law responded to that, and everything in the system responded to that. And it literally was the have period. We used inflation as a way to increase the incentives to home builders and to Lord knows what--doctors, hospitals, you name it.

I think you all know, because others speak to this now with greater frequency, that we have done the same thing to ourselves in the health care area. In fact, maybe we adapted all of this from the health care system, where we first invented Blue Cross and Blue Shield as a way to make sure doctors and hospitals got paid in money rather than in pickles and sides of beef and things like that. Then we invented group rating and we got the young to pay for the old, and the healthy to pay for the sick, and we got the employers to provide insurance for the employees. And then we got the government in 1954 to say, "That's a great thing, let's have the employers write it off on their taxes, and let's have the employees write it off on their taxes," so nobody pays any taxes. That, of course, was followed by, "If this one's free, let's put everything we can into it." So health insurance was destroyed--we converted it to the company health plan or something like that, and anything you can think of from eyeglasses to toothbrushes to whatever got dumped into that plan.

Then it became just like the house in the suburbs. You want a doctor, go get a doctor; you want a hospital, you want to stay in a hospital for a week or two weeks or three weeks, go stay in a hospital for a week, two weeks. That wasn't the worst of the problem, because all that gave us was a surplus of doctors, a surplus of hospital beds, all that sort of thing. The worst of it was what it did to ourselves.

Barney Clark could get $205,000 out of a bankrupting trust fund to experiment with a new heart for four months. His wife could then, after the funeral, come to Washington and pose with Ronald Reagan in an ad for larger labeling on cigarette packages. Why? Because Barney smoked two and a half packs a day for 25 years, right? She and Reagan, apparently, thought to put labels on that package was the way to deal with Barney's heart. Now that was a few years ago. But we all have been that way. That's the way. Take your heart, take my liver, cancer, you name it. I don't have to take care of myself because somebody else is responsible for me.

So we loaded up the health plans, we loaded up the system with demand, we made sure employees who went to work for somebody never had to pay for their health care, and we said, "That looks good for employees, now let's take care of the poor and let's care for the elderly and the disabled the same way." So we passed Title XVIII and Title XIX of the Social Security Act, and we took care of the poor. We didn't really take care of the poor, but we made a good stab at it with Medicaid. And we took care of the elderly and the disabled with Medicare--Part A and Part B. Only, in retrospect, we did a funny thing. We didn't have them pay for it either. We had these employees sitting down there paying for the elderly and the disabled. The elderly and disabled didn't pay for it because the employees were paying for it. Nobody was paying for their own health care--they were paying for somebody else's health care for the most part.

"Nobody was paying for his own health care . . ."

So there were no curbs of any kind on the utilization of the health care system. A good doctor couldn't get a patient to quit smoking. The patient would go someplace else where he wouldn't be harassed by that guy telling him to quit smoking all the time. And good hospitals, or hospitals that try to be efficient, have the same kind of problem. There was no incentive to do things outside of a hospital, certainly, because people loved to come and be waited on. Clean sheets--really great stuff.

No More "Free Lunch"

Then somewhere in the mid-1970's, we discovered, in the political sense, that all of this stuff we were going through in America--the houses, the farms, the health care systems, the three cars in the garage--did not always mean quality. In the auto industry, for example, it was not until we faced overseas competition from Japan that we became more concerned about "quality" than "chrome". I could go into other examples--but you all know what I mean. Most of you, I think, are my generation, and so you know what our folks did for us. At the time, it was really terrific.

But in the mid-70's, Jimmy Carter came along and said, "I'm just a peanut farmer who used to be a governor. A peanut farmer from Georgia. And the one thing I know is that, by God, we better get those guys in Washington to live within their means, the way we have to live within our means." Well, none

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of us have to live within our means, even in Plaines, Georgia. Not in Duluth, not in Minneapolis, none of us live within our means. But he said it, and people said, "That's right. We should live within our means."

And we invented the balanced budget, and we invented getting rid of bureaucrats, and we invented throwing out waste and abuse. We threw Gerry Ford out of office, and we put Jimmy Carter in. When he left four years later, the budget deficit had doubled, the national debt had doubled, inflation was 14%, interest rates were 21-22% and he got thrown out on his ear. He was replaced by a 70-year-old movie actor who said the same thing! Same old line! And what did he do? He doubled the national debt from $715 billion to $1.517 trillion. But he did Jimmy Carter one better--he tripled the annual debt service. He took it from $42 billion in 1980 up to $137 billion this year. He did him one better, and when he went to the polls in 1984, you know what happened. Except for 3,170 people in Minnesota...

So, what was the meaning of that election? What will the Congress do now? Will it balance the budget or won't it? Well, if you look at the election results, why should we? The guy that doubles the budget and triples the debt service gets reelected by the biggest election ever--why should we do that? In January, we said to him, "Mr. President, you just got re-elected. We can't all have these freeze plans of our own, you know. We have got to get together in one plan." When we asked him, "How do you balance the budget?" he said, "I've got a plan for you." So he presented it to us and it took us down in 1988 to a deficit of only $144 billion a year. The President doesn't want to balance the budget. He wants to get rid of a large part of government. He's just starting with 17 programs this year, but he'll continue.

There is a large body of opinion that says that because we, the national government, have done so much so poorly we should be sent packing. If you read the Constitution, you probably cannot find graduate medical education in there anywhere. There are even some things in the Constitution they don't think we should be doing, like controlling the currency, national defense, the social insurance system, and debt. That is the view of a lot of people in Washington. Everything else can be better done somewhere else. Now I don't argue against everything else being done better somewhere else. It is done better elsewhere. But it is not financed better elsewhere. We can go to Cook County or L.A. and we can get examples, or New Orleans, and we can get examples.

One of the things that is lacking in Washington now is a sense of national purpose. We are so torn up with the national government not being able to balance its budget and being wasteful and all that sort of thing that we have lost sight of

national purpose. We cannot think in terms of a national obligation to the poor. We cannot think in terms of a national desire for high quality education, because education is something that is done somewhere else, i.e., as close to home as possible. But whoever said that that converted into saying Washington has no responsibility to gather the resources of the nation and devote them to the purposes that are being done in the local community?

Another problem you have to deal with here is the fact that most of us, contrary to what I said about the election, have finally decided, with you, that we need to balance the budget, that that deficit is unconscionable. It isn't just because I now have an 18-year-old, a 20-year-old, a 21-year-old, and a 22-year-old that I just feel guilty as hell saddling with all this debt. We have finally caught on. Deficits must come to an end. That budget must balance, mainly because we have to learn how to run this place more efficiently. If you want 21 more Peacekeepers to point at the Soviet Union, Mr. President, then let's ask the American people to pay for them. Do not ask my children to pay for them, because they aren't into the MX yet. If you really want this to operate as a democracy, then stop operating off of debt. If you want people to be more involved with their health care, have them pay a deductible or pay some cost-sharing. The theory is that if you pay some money, you're going to be more careful about the quality. The necessity, then, Mr. President, is, if you want your MX, let us ask the people to pay for your MX. It is too easy in this place to pretend that those things don't cost anything.

"The theory is that if you pay some money, you're going to be more careful about the quality."

I want to say to the military people in this room, I would be prepared to vote for the Peacekeeper on its merits, but I am not going to vote for it as long as we refuse to pay for it. And I want to tell you on behalf of the people in Hutchinson and Jackson and Luverne and Slayton and all the rest of those towns I mentioned in Minnesota who are dying, one at a time--and literally, the suicide rate is almost off the wall--I want to say to the President of the United States, "You are no longer getting a free lunch on anything."

So it isn't just me. I must sound like a Democrat. But it isn't just me, folks. I mean, we're all kind of Independents now. There are a few folks out on the right wing, and there are a few folks out on the left wing, and most of us are looking for answers in the middle someplace.

One of the answers is clearly, if everybody pays for what he

gets, everybody is a heck of a lot more concerned, about the quality of that house, the quality of that hospital day, the quality of that medical care, or the quality of that national security.

So what are we going to do, literally, when Congress reconvenes? We will eventually get around to something called the Republican leadership compromise with the White House over the budget. And many of you will be led to believe that it is the budget over which we compromise. Part of my talk here today has to convince you that it is not the budget we are debating. That is only the direct spending part of the budget. That is only the $600 toilet seats and the waste in the food stamp program, and that sort of thing that we're debating. Debating whether to get rid of the Soil Conservation Commissions all over this country, debating whether we should get rid of Amtrak, that debate. That's where I write out a check as a senator and send it out to somebody to spend--over to the Defense Department or the V.A. or some other place.

The President talks of reforming the tax system in this country. We are going to make it simple, and we are going to make it fair. The guy next door who pays less taxes with the same amount of income and just got done getting a refund when you had to send in a check is going to lose that privilege. Now, it would be much better if the President said, "We don't raise revenue anymore with the tax code. We spend money with the tax code. Only it's the money that you spend, not the money that I spend."

Here are some other examples. A Cessna ad ran in the Wall Street Journal last year. It said there were two reasons to buy a Cessna single-engine aircraft, and I don't know what the second one is because the first one was because the IRS will give you all your money back. Really. Well, you know the IRS does not give money, it takes money. So how do you get the money? Well, you get the money with an investment tax credit, you get it with ACRS, depreciation, you get it with interest that you borrow to buy the Cessna single-engine aircraft, and a variety of deductions. That's how you get all your money back on an airplane. I priced them out. Their cheapest one is $44,000; the most expensive one is about $219,000. The government is buying $219,000 single-engine airplanes for people in this country. But we have got to get rid of Amtrak, soil conservation, economic development administration, and so on.

Here's another example. I just bought a secondhand Olds Cutlass Sierra. It cost me $9,920 with sales tax, so I went to my bank and I borrowed $10,000. And my banker was good enough to give me five years to pay. What I said to him is I want to do nothing but pay interest. Okay? So, now, by the fifth year, at least, you will have bought Senator Durenberger a secondhand Olds Cutlass Sierra. And I think it's just very nice of you to have done that.

Now that I've told you that, go back and think about all of the things you've charged me for. Who's got a yacht here, who's got a big boat? Who's taking the trips to the Caribbean to keep up on their continuing medical education? It keeps a lot of steamship companies alive.

But, folks, we have got a $225 billion a year add-on to the federal deficit. It's going to be $2 trillion by the time Ronald Reagan goes back to California, and it is going to be $3 trillion in debt by the end of this decade. And in our efforts to try to cut it down to $175 billion, or $165 billion, we are going to freeze the Medicare program. We are going to freeze the Medicaid program. We are going to freeze, for the second year in a row, physician reimbursement under Part B. We are going to cut 50% out of indirect medical, after we promised you we were going to give you more money than we thought you deserved, but we didn't have a severity index, so we'd pay you with money instead, and after we promised you that, we're going to come along and take it away to the tune of, I don't know, $2.7 billion, or something like that.

And you know, they talk to you about freezes. They say freezes are a one-time thing. Well, if a freeze plus this year gets you from $225 billion deficit to $165 billion deficit, what the hell do you think we're going to do to you next year? That's what bothers me. That's why I wanted to show up today and talk to you about graduate medical education. That's why I haven't gotten to graduate medical education yet, because, on the hill, they could care less about GME. It sounds like a new automobile company.

You'll never convince them it's a problem, because when they go to the hospital and pay for the doctors, they can't see the bill. I can't see it. But I'll tell you, whoever is now buying my health care for me knows it's there. And they're saying to me, "Dave, if you want to get less expensive health care, I can buy it for you without the doctor education in it. I can buy it for you without the poor people care in it. I can buy it for you without a lot of other things in it. Because I'm going to go out there and I'm going to buy just what you need. Not what society needs."

And that's where we're going. I think you all know that as you watch the competitive medical plan system begin to build. I am all for that. Yes, it's hard to come to Chicago, and it's hard to go to L.A. with the biggest general hospital in the country, and it's hard to go downtown Minneapolis and say to those folks, you know, that somehow it looks like I don't care about the poor and I don't care about medical education, because I do. But I also care about the fact that we were all getting priced out of our hospitals and our doctors and our health plans and our everything else. I care about the fact that a whole lot of black, young, uneducated, poor mothers were fill-

ing a lot of $4,000 a day ICU's with very low live-weight babies that didn't have to be born then if we had just had a few measly little dollars to spend on prenatal care. But we're out of that. The ICU's and everything else have taken up all the money. We don't have the money for prevention. We don't have the money for wellness. At least, we don't think we do.

When my mother sends me a living will, she thinks that there is not enough to go around. I'll take you back to Mrs. Barney Clark sitting in the White House and the $205,000--that was a waste of our resources. And I will walk you, or you can walk me better than I can walk you, through this health care system that we've built up in America over the last 30 years, and you can point out to me the inefficiencies in the system. And you can point out to me how it could be done better. I know that.

"I'd like to put the health care system back in your hands . . . but I can't do that unless I know what all these things cost."

So I'd like to put the health care system back in your hands in some fashion. And the best way I know is to empower the consumers of health care in this country with the ability to make choices of health plans, choices of doctors, hospitals, choices of staying well, and getting rewarded for it.

That's my objective. But I can't do that unless I know what all these things cost. And today, I do not know what graduate medical education costs, because it's buried there someplace. If I'm going to buy it in society, I know that as an individual, I am not going to buy it as part of my health plan. I just know that, gang, I am sorry. But my health plan, like my house, has been taken from a $50 a month obligation up to a $300 a month obligation. So I think, and I am speaking on behalf of all Americans, not as a United States Senator, I think I don't have the money to buy medical education in my plan, because I personally don't need it. Even though I know society as a whole needs it, I don't believe my health plan is the place to buy it. I think the same thing is true with the care for the indigent.

Society has to find a way to provide for the indigent, society has to find a way to provide for medical education, in much the same way it has traditionally found other ways to provide for other things. How we're going to do that, Lord only knows. I am just here to alert you to the fact that budget cutting is going to kill you, unless you can somehow help us make some sense out of it. Tell them that you've just bought a senator an Oldsmobile that he doesn't need. Tell them that. But don't tell them which senator. Tell them you just bought a big boat that you don't really think the taxpayers should pay for.

Look at automobile companies: $6,000 a year for health plans at Chrysler. They got $2,500 added to every automobile in this country by keeping the Japanese out of here four years ago. They guaranteed $23 an hour jobs for 44,000 in Detroit, a city where they have a hell of a hard time feeding and clothing and providing health care to the poor. But the auto workers got $23 an hour. And inside those $23 an hour jobs, they got $6,000 a year worth of health insurance that they don't need. And it was paid for by guess who--you! In the 40% tax bracket, you picked up 40% of $6,000 or $2,400. You paid those people to have a big health plan. No first dollar coverage, no cost. I mean, it's all first dollar--no cost-sharing--no nothing. They have the gall to sit up there and add $2,500 to the price of every car you buy, send the $2,400 bill per person to the taxpayers for health insurance they don't need, and the guy says this is the free enterprise system. Lee Iacocca ought to run the Defense Department.

That is crazy. But, they got away with it. I think they got away with it once, but that's as often as they're going to get away with it, because there is no such thing as a free lunch.

Let us talk about fringe benefit taxation. Let us particularly talk about the business people who are so excited about dumping on doctors today. I tell you, I really get it when I go around to these companies, and I meet the new benefits manager in these companies. They are so excited now because they are finding out that one doctor costs this, and the other doctor costs that, and the third doctor, he gets a different price. They get so excited about getting out there and ripping off these doctors, because obviously the doctor in town gets paid twice as much as the employee benefits manager for the company. So they are just dying to go after doctors. And they are just drooling, I can see it. They've got a free ride too. That needs to end.

I know that when something is wrong with me, I want to find somebody who, as quickly as possible, can diagnose what that is, get me into the right treatment setting, and give me the best care in the world. That's all I know. I am out to try to save graduate medical education from competition and consumer choice, which I am a very strong supporter of. I find consumer choice and competition to be the only answer to this problem, but I know that it makes it impossible for us to deal with these other problems in the old subsidized way. You set a price on them, we can make some decisions about how to deal with them.

I threw out the earlier block grant bill just to get people thinking. That bill said there is a state obligation as well as a federal obligation. The block grant is not a very good way to go about it. There are better ways. Senators Dole and Bentsen and I are working on putting into implementing language some of the things talked about today, the general notion being to take the Medicare trust fund and pay people for the first

three years of graduate training. After that, we don't know who's going to pay, but at least you'd be guaranteed that we would support the first three years of GME, and you'd have a source of funds.

I want to say one more thing about the budget this year. You know that they have got this 50% reduction in indirect, and I think we're going to settle somewhere in the middle, like at maybe 25%, which is 9%. I may not start that low, but I'll try to settle that low. The other one is just much too high.

We have to deal with Part B reimbursement. We have to deal with the foreign medical school graduates, though I am really talking about the foreigner who graduates from the medical schools. I don't think they have any right to go into our Medicare trust fund to get educated in this country.

Those are the kinds of issues that we are dealing with. The direction I am now going in financing GME is to follow the leadership of others, which is all I ever do. Just like a sponge, I go around and pick up ideas here and there and squeeze them out on somebody else. Right now, people like Petersdorf and Heyssel seem to have the best idea in GME.

Direction Is Needed

Ladies and gentlemen, I cannot say this strongly enough: I have been trying to do something about graduate medical education now for about two years, because I care a lot about it. But I don't have the right answers. You cannot say, "We can't find an answer." I beg you, don't reach that conclusion. Work at this until you have reached some conclusion that deals very explicitly with the problem. At that point, come to us and say you know the answer to balancing the budget and the deficit is not a checkbook answer. It's not just cutting spending or raising taxes. It is all in thinking differently about the way we finance the delivery of public services. And only in health care today are we doing our bit. They sure as hell are not doing it in the Defense Department, let me tell you that. And they are not doing it in the social insurance system in this country, and they are not doing it in education--although it's just starting to come in education. But in health care, we are changing this system. We are saving the American consumer billions and billions of dollars already. And hopefully, we're never going to do that at the sacrifice of the quality of health care.

Thank you very much for the opportunity to be here.

REDEFINING HEALTH CARE THROUGH EFFICIENT USE OF MEDICAL RESOURCES

PRESIDENTS FORUM

SPECIAL COUNSEL HEARING EX. 240 PFZ 21

PROCEEDINGS FROM THE FIFTH SESSION OF THE PRESIDENTS FORUM

This monograph contains the actual proceedings of the fifth session of the Presidents Forum held on April 27 and 28, 1985, in Miami Beach, Florida. Seventy physician presidents met with economists, legislators, and health-care administrators to examine alternative uses of medical resources. The monograph begins with an assessment of Medicare and Medicaid by Carolyne Davis, Ph.D., Administrator, Healthcare Financing Administration. Dr. Uwe Reinhardt follows with views on the direction of America's health resources. Discussing the rationing of health care vs. new technology are Dr. Peter Farley, former president of Cetus Corporation, and David Jones, C.E.O. of Humana, Inc. Michael Bromberg, Executive Director for the Federation of American Hospitals, and Charles Ewell, President and C.E.O. of American Healthcare Systems, provide opposing views on investor-owned and not-for-profit hospitals. James Kilpatrick also spoke at the Forum, relating anecdotes from his years as a Washington journalist. The monograph continues with a discussion of the changing relationships between physicians, administrators and patients by Dr. Victor Fuchs, Economics Professor at Stanford University; a look at the impact that budget cuts could have on medical research presented by Frankie Trull, Executive Director of the Foundation for Biomedical Research; and a view of prepaid health plans and competition by Senator David Durenberger (R—Minn.). Keynote addresses were given by Arkady Shevchenko, Former Soviet Ambassador to the United Nations, and Jeane Kirkpatrick, former U.S. Ambassador to the United Nations and cabinet member under President Reagan.

PFZ 215

INTRODUCTION

Dear Colleague:

With the completion of the fifth Presidents Forum, it is my pleasure to provide you with a monograph summarizing material covered at the meeting.

The fifth Presidents Forum focused on maximizing the value of shrinking health-care resources. Special emphasis was given to the hospital sector, new technology development, alternative modes of care, and recent changes in health-care financing and its effects on patients, physicians and administrators.

The medical community is being challenged as never before by many health-care resource issues, and the conflict between the need to economize and the imperative to provide quality care is generating new alternatives within the health-care system. As physician leaders, you will help to shape the health-care sector during this time of complex change.

I hope this monograph will provide you with a useful overview of some of the critical new issues in health-care policy.

Sincerely,

Joseph T. Curti

Joseph T. Curti, M.D.
Vice President
and Medical Director

PFZ 216

ARKADY SHEVCHENKO

KEYNOTE SPEAKER

I have great respect for the medical profession; perhaps I would have been better off as a medical doctor. I don't know. Anyway, here I am, far away from my motherland, in another country, a country which I have come to love and to consider my other motherland, the United States.

Some serious political matters concerning the Soviet Union are of interest to us all. What's going on now in the Soviet Union with Mikhail Gorbachev? What can we expect from developing Soviet-American relations? And what are the dangers or the threats to the world in which we live?

I'll begin with the new Soviet leader. Is this man essentially different from the other, older members of the Politburo, which rules the Soviet Union? Will he really try to change the Soviet system? The answer to both of these questions is, probably, no. Of course he is much more dynamic than his predecessors. He has a certain charisma and he charmed even Margaret Thatcher during his recent visit to the United Kingdom. It's true that the man has a certain appeal because he's an energetic leader. But there are a lot of others like him in the Party.

Western observers—Sovietologists or Soviet analysts—have been asking how he was able to move to the top so quickly. The answer is very simple, and it is one which members of the medical profession can understand better than anybody else. He was the leader of the area of the Soviet Union where the country's two major medical resort facilities are located. These are the facilities to which the old leaders of the Soviet Union go each year. And as First Secretary of the Party in that region, Gorbachev met all the late leaders of the Soviet Union: Suslov, Kosygin, Brezhnev and, of course, Andropov.

It's as simple as that. There is nothing magical about it. Nothing indicates that he has exclusive abilities or capabilities. He simply became known to the old leadership and was moved to Moscow. There are hundreds of other Gorbachevs in the Soviet Union with the same ability and with more or less the same education.

It's now frequently claimed that the Soviet Union has a leader who is highly educated, a graduate of Moscow University with a legal and an agricultural education. But he never worked in either profession. As a student, he was Secretary of the student Party organization. This activity took up more of his time than his classes. He never worked as a lawyer or as an agricultural specialist. He's a Party professional, what they call an "Apparatchik" in the Soviet Union.

Out of the nearly 80 million Communist Party members in the Soviet Union, there is a core of about two million professional members. These two million include those who occupy the top positions in the military, and those who are in the KGB. Together, they rule the Soviet Union. Adolf Gorbachev is one of them. In essence, he is not much different from other Soviet leaders but he may exhibit a new style. He may be able to move the Soviet economy or to resolve some social problems. But he didn't initiate this process of change. It started long ago. Ever since the last years of Brezhnev and Andropov, Soviet leaders have understood that things cannot go on as they've been going for years and years.

There are many problems in the Soviet Union, and the workers have lost interest in working. Russians joke that there is no unemployment in the Soviet Union, but nobody works either! (It's not true that the Russians don't have a sense of humor.) This joke reflects the depths of worker apathy. They are not interested in working because they have no incentive. If you work better, you can get a little bit more in salary. But if you don't work well, it doesn't really matter. If you come to your office at seven o'clock in the morning, drunk, which often happens in the Soviet Union, it also doesn't matter. Because if you're fired from one place, you just go to another.

There are other serious problems within the Soviet Union. There is a big discrepancy between the military and civilian

sectors of the Soviet economy. The military sector gets the keenest attention of the Soviet leadership and the most resources. As a result, the Soviet military is quite modern and capable. But 80 percent of the computer chips used in the Soviet military industries have been either bought or stolen from the West.

Although the Soviet economy is much more advanced than that of any Third World country, it is quite backward compared to the West. The standard of living of the Soviet population is very much behind that of any Western industrialized country. The irony is that the Soviets claim that they are now in an advanced stage of socialism. What kind of socialism, and what kind of society are they constructing?

Their system cannot produce a proper standard of living for their people so long as the people do not have elementary freedoms. Soviet people cannot leave the Soviet Union, except for Jewish emigration, which now seems to have largely ceased. The only reason for this exception was that the Soviet government wanted political gains. Generally speaking, however, Soviet citizens cannot leave their country, or even see the outside world.

Americans often don't realize or appreciate what they have. I don't mean to suggest that there are no problems in the United States or in the West, but if one were to compare these two societies, one would find the Soviet regime denies its people both material comforts and elementary freedoms.

There's no free press in the Soviet Union. Most people there have never seen any foreign newspaper. They see only the censored Soviet press, or television programs screened and approved by the government. Americans often don't realize or appreciate what they have. I don't mean to suggest that there are no problems in the United States or in the West, but if one were to compare these two societies, one would find the Soviet regime denies its people both material comforts and elementary freedoms, such as free access to information or freedom of movement. Yes, even the movement of the Soviet people within the Soviet Union is restricted. Moscow, Leningrad and the other major cities of the Soviet Union are restricted areas. Only people who have been promoted to a Party position or a government post can move to these restricted areas. An ordinary Soviet citizen cannot just move from Siberia, and say he wants to live in Moscow. He would have to get permission to do that, and permission is rarely granted.

In Soviet medicine, the Soviets have what they call universal free medical service, but what does that really mean? Many of you may have visited some of the best clinics in Moscow and met with brilliant medical specialists who were quite accomplished in their field. But there's a big difference between the showplaces in the Soviet Union and the reality of Soviet health care. There's a big difference between what is going on in Moscow and what occurs in other parts of the country.

My mother died a few years ago. She couldn't receive a much needed operation where she lived, even though it was not considered a very remote part of the Soviet Union. I brought her to Moscow and I met with the Soviet Health Minister to try to get help for her. I had come all the way from New York, but they wouldn't accept her in the Moscow hospital because it was a complex operation which they could not do. That's quite revealing.

When I was a young student living in Moscow I had an appendectomy, but because they didn't have enough anesthesia I suffered unbelievable pain. And then I spent an entire day in the hospital corridor, because they had no room in which to put me. That is free Soviet medicine.

We need to develop a much better understanding of this Soviet society. It is a society whose leadership is unconcerned with the interest of the people. It might seem at times that the American government or an American leader does not think about the interest of the common people in this country. But there is something fundamental in this society which gives the people at least some control over what's going on. Here there are elections, and the president cannot stay in office more than two terms. Your leaders must explain to the people what is going on in government. These things do not exist in the Soviet Union. There are elections to fill seats in their parliament, the Supreme Soviet. Of course, in the whole history of the Soviet Union, no candidate for a seat in the Supreme Soviet has ever failed to be elected. It's a fantastic society. Never in any vote in the Supreme Soviet has anyone either voted against or even abstained on any piece of proposed legislation. That shows you what kind of a body it is. It's a sham.

Everything is decided by the Party, and everything in the Party is decided by the Politburo. The Politburo was made up of ten men until just a few days ago, when it was decided to add a few more. Never in the history of the Soviet Union had the Politburo been so small. So Gorbachev and the other members decided to increase it to thirteen.

It now remains to be seen whether it's better for us to have younger men like Gor-

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bachev in power, or whether it was better to have had all those invalids. I think overall it will be better for us with Gorbachev. Even if he's not seriously different from his older predecessors, I think he'll be interested in trying to do something to improve Soviet economic performance, and there's a lot of room for improvement there.

Even within the Soviet press there is a lot of open criticism of Soviet mismanagement. Soviet managers are, regrettably, not really equipped with the qualifications required by modern society. (On the bright side, at least the press-criticism of that issue is still open.)

There are also press accounts about the shortcomings of production in the consumer sector. This is a prime area of interest to the new Soviet leader, and he will try to increase the number of people in the Politburo who follow his lead on improvements in this area.

With regard to foreign policy and the future of Soviet-American relations, can we really expect dramatic changes? The answer is no. Gorbachev is still dominated by the old guard and the old policies. Without Gromyko, who was my former boss and mentor, Gorbachev would never have become General Secretary. The support of Gromyko overcame the resistance of the older Party men. Gorbachev's rival for the post of General Secretary was Romanov. Romanov lost the behind-the-scenes battle for leadership, but that doesn't mean he lost all his power. He is still at the top of the Politburo.

We must remember that Gorbachev's position is not like that of the President of the United States. He doesn't have almost unlimited authority in the administrative field. True, the American President doesn't have unlimited power either. He shares it with the Congress of the United States. But the General Secretary of the Communist Party, unless he's a dictator like Stalin, doesn't have even half as much power as the American President. He is controlled by the Politburo.

This brings us, finally, to the question of the future of Soviet-American relations and what we can do to affect change. Yes, there are really serious differences between the two societies. The Soviet leadership, particularly the Old Guard, believes they will be the ultimate winners in the historic competition between what they call "decaying Capitalism" and the Soviet style of socialism. They are also primitive enough to think that this victory will happen tomorrow. They understand the realities, but they do have this belief.

They talk a lot about peace, but even peace has different meanings in Russia. For them, peace may mean world rule. They really do believe that they will be winners in the historic competition, and this is a dangerous philosophy. This philosophy of world competition is being taught in the schools, in the universities, everywhere. They are being taught that they will win, and that is something which we have to understand.

On the one hand, we have to understand this philosophy. But on the other hand, we have to also understand that both the Soviet Union and the United States have the capability to destroy each other—and the whole world as well. A major confrontation between the two superpowers would be a disaster and perhaps spell the end of civilization on earth.

While we must understand the differences between the two societies, we cannot, in my view, allow those differences to keep us from talking with the Soviet leaders and grappling with the issues.

And we should not forget that the Soviet Union is more than just a political entity. It is a great nation with great people. It is the nation which gave us Chekhov and Dostoyevsky. Even as we deal with the political stance of the official regime, we should not forget that behind that regime are a great people and a great nation.

For all these reasons, I think we ought to be realistic in dealing with the Soviet Union. By realistic, I mean understanding who they are and with whom we're dealing. We have to deal with the leaders, whoever they are, because they are there. We cannot change that. The Soviet people have come to accept them. We must do the same, even as we recognize that the leadership may not be fully representative of the citizens. We have no choice but to talk with them and try to find some solutions to problems; problems such as the risk of nuclear war and arms control. We should also be interested in trade with the Soviet Union, and in exchanges of expertise. There are fields of medicine in which the Soviet Union is very much advanced. There are areas in which they have achieved quite a lot and we can learn from them.

Both the Soviet Union and the United States are great nations. But we are different. We have to recognize and understand these differences, even as we continue to deal with each other.

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CAROLYNE DAVIS

Medicare and Medicaid: Redesigning the Health Care System

It's no secret that two-thirds of Medicare dollars pay hospitals. In 1982, we said we absolutely had to do something about this, and clearly one response was to restructure that system and give hospitals new incentives to manage themselves better.

Let me begin with a brief overview of the situation when I joined the Reagan Administration in 1981. At that time Medicare and Medicaid were spending $54 billion. This year we're spending $74 billion for Medicare alone and $23 billion for Medicaid. The $97 billion total means that over the last four years our budget has nearly doubled.

In terms that are a little easier to understand, we're spending $11 million an hour on Medicare and Medicaid this year, compared to last year's figure of $9.6 million an hour. It's that kind of growth rate that we are struggling with as we try to restructure the system and bring it under control.

With Medicaid, our general direction has been to aim for more state flexibility by increasing the states' abilities to manage their own Medicaid programs.

Medicaid is not as similar to Medicare as many people think. Roughly 50 percent of the dollars in Medicaid pay for long-term care services, such as nursing home care. That's quite different from Medicare, an acute-care benefit program with only about one percent of its dollars set aside for nursing home care. So these two programs need to be dealt with somewhat differently, not just because they differ in terms of structural design—of where the dollars flow—but also because Medicare is totally Federal-run and a Federal responsibility.

By contrast, Medicaid is shared with the states. Over the last several years, the states have moved heavily into home-based and community-based services, providing home care in lieu of institutionalization for chronic care needs. About 65 waivers have been given to 46 different states for that purpose. They're now focusing more on primary care and the delivery of services to the acute population, and requests have increased for "waivers on the freedom of choice," primarily to promote HMO's.

With Medicare, we've undertaken three major initiatives. First is reimbursement reform, an attempt to redesign the way we pay for services. Second is the whole idea of coverage for alternative ways of delivering care, such as using ambulatory surgical centers and recent developments in the HMO market. Third is the initiative to increase consumers' awareness of the costs of care, through such vehicles as increased copayments and deductibles, increased sharing of information with the beneficiaries, and the more recent proposals to tax health insurance benefits.

Regarding the first initiative, reimbursement reform, why was it undertaken, and why was prospective payment for hospitals the number one priority?

It's no secret that two-thirds of Medicare dollars pay hospitals. In 1982, we said we absolutely had to do something about this, and clearly one response was to restructure that system and give hospitals new incentives to manage themselves better. That was heightened by the 1982 Social Security Trustees report on the hospital insurance trust fund, which indicated that the fund would be broke by 1985 or early 1986. Congress accepted that report and swiftly acted on our recommendation to move to a prospective payment system for hospitals. People sometimes ask, "Why did that happen so quickly?" There was a fairly general agreement among the various sectors on the hospitals' side that, indeed, a prospective payment reimbursement system should be implemented and that it should be the DRG system.

Why was the DRG system selected? One option was a budget negotiation system, which obviously would have been terribly intrusive, and quite dependent both upon the negotiating skills of the individual hospitals and an increase in federal staffing. And I can assure you that we were not about to see an increase in staffing on the Federal side, insofar as the Administration's position is that the size of government will decrease. Indeed, our own agency has been reduced by 20 percent over these last four years. As we looked at the various systems being tested, it became very clear that a hospital's case mix ought to make a big difference in terms of fair and equitable payment. The DRG system has to

allow for that to happen.

But doesn't the DRG system intrude upon the internal workings of the hospitals? DRG certainly is a form of price control. In that respect, it seems to run counter to this Administration's direction. But I think it's important to remember that in 1982 many choices weren't available to us. We absolutely had to do something about bringing that inflation rate down.

We had two choices, either adopt internal regulatory controls or try to find some middle ground, perhaps a regulatory device which allows more individual decision-making at the institutional level. We opted for the DRG system, believing that giving institutions an aggregate budget would allow administrators, physicians and others to make their own determinations regarding those allocations. Finally, we saw DRG as an interim step toward a capitated or vouchered system, which is where we hope to go in the future.

Three major concepts are embodied in prospective payment. First is the setting of a known payment mechanism ahead of time, or prospectively, which allows for the individual health-care delivery entity to make its own budgetary decisions based on a known budget. Second is the concept of clustering services together in order to decrease utilization costs. Third is the whole concept of risk-reward. In risk-reward, we set the fair payment. If your costs are less, you keep those extra dollars. This is a very powerful incentive for changes in behavior.

These three concepts are very important because they will also be embodied in the future reimbursement reforms which emerge as we begin to look at other payers and providers.

What has been the outcome of our first two years in the prospective payment system for hospitals using the DRG? We are phasing into a national rate system. In October we embark on year three, which I believe will see even further standardization of rates.

We see a slight reduction in the length of stay in the Medicare population. Our average length of stay is now about 7.5 days. That's the most dramatic decrease in the history of the programs.

There's been a decrease in overall admissions. Critics argued that, because we were paying on a per admission or per discharge basis, we would see a great increase in the number of admissions. We had a bloody battle for at least a month with our OMB colleagues, who believed that the system needed volume control. I can't help but remind them now that volume controls proved to be necessary.

Since admissions have been dropping (they're now about 4.7 percent less than initially projected) a slight increase in referrals to home-health services and skilled-nursing facilities has occurred. Many people had predicted a huge increase in those referrals, but this has not occurred to any discernible extent.

Specifically with regard to quality of care, our critics indicated that there is a risk that individuals would be sent home prematurely and, consequently, would have to be readmitted for additional care. It was also feared that one way to get around the system would be to purposely discharge patients early, fully knowing that they would have to be readmitted within a couple of days. We didn't think that was going to happen, but we kept watch on it, and found that only about 1.3 percent of all our patients are readmitted within seven days. We think that's well within the norm.

Among the activities going on [illegible] the hospitals, there is an increased emphasis on tracking. In most hospitals, the [illegible] of the computer emerged almost overnight as a major management tool. The merging of clinical and financial data clearly became of great interest to all who worked within the institution.

It helped to assess developments and perhaps to change behavior patterns. I detect a clear movement to assign either a DRG coordinator, a primary care nurse or someone to directly analyze and track what's going on with the various DRG's, to permit the hospital to respond.

There is now much more interest in early-discharge planning, patient teaching, better coordination of patient care between physicians and nurses and a new involvement of the board of trustees. Largely, I suppose, the boards' attention is a result of the new realization that they themselves, as a part of their fiduciary responsibility, could potentially be placed at risk. We've seen a marked increase in the direct involvement of boards in running the institutions.

Another by-product of the assessment process is the development of a genuine sense of community need. Out of that has grown some very interesting diversification. Clearly there's been a move to specialize. As institutions have begun to use business practices, they've realized that in communities with more than one institu-

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tion, some services can be merged.

For the first time, they are regarding DRGs as a measurement of both the direct and an indirect product of patient care. As you track, you realize that volume multiplied by unit cost gives you your total outlays. If you have a low volume, then one way to lower total expenditures is to increase volume.

In today's competitive environment, one way to do that is joint planning. An institution with a low volume of a particular service may relinquish its market share of that service to the higher-volume institution. In turn, the first institution may accept another type of case from the second. Each, in effect, becomes a specialist with a higher volume in its specialty. This is done in the realization that a higher volume lowers the cost of a given DRG.

Improved quality is another benefit of this trend toward specialization. A Public Health Service study showed that where there is a high volume of any particular procedure, a higher quality of care results.

Improved quality is another benefit of this trend toward specialization. A Public Health Service study showed that where there is a high volume of any particular procedure, a higher quality of care results. That study covered nine high-tech procedures. It showed a 13 percent reduction in the mortality rate and about 4 million fewer days of hospitalization at institutions which performed a higher volume of those procedures. Clearly, this suggests a way to enhance quality of care.

Nevertheless, some critics have indicated that quality of care could suffer as a result of these new modes of service delivery. So in order to have a system of checks and balances, the Peer Review Organizations were developed. They have a mandate to examine and report on a number of quality indicators.

We are also now very interested in studying the causes of practice variability observed around the country. Many of us are familiar with Dr. Wennberg's work. Indeed, some of our research funding has been directed into this area, and I think you'll find that next year's research budget will have even more dollars allocated to looking at this activity.

The propective payment system is not perfect; we know that. Some fine tuning needs to be done. We must, of course, look carefully at the wage index. But more important, I think, is to structure what we call a severity-of-illness index. Right now we're funding six studies in an attempt to develop such an index. We truly believe that there should be a severity-of-illness index to modify, if you will, the individual DRG for its own variability.

Presently, only the acute-care hospitals are within the DRG system, with the exception of four waivered states. We are collecting the DRG data for our psychiatric hospitals, long term care, rehabilitation and pediatric hospitals. And we are working with each of the professional societies that represent those hospitals, in order to collect that data. I think you could probably assume that next year there will be a report to Congress in time for implementation in the fall of 1986 or fiscal year 1987.

Our data show that, as we look at the Medicare Trust Fund this year, we have gained about 11 years of solvency. The fund will not go broke until 1998—instead of the original prediction of 1986. However, we ought not to rest on our laurels. That trust fund prediction is based on several *if*'s. First, it assumes a rate freeze this year. Second, while it's also very true that the next 12 years appear to be fine, the 25-year projection shows significant problems. The fund is expected to remain solvent for the next 12 years, but in the last 13 years it can be expected to pile up a deficit of almost a trillion dollars. So it's clear that we have to continue reworking the system.

Home health care—the subject originally scheduled for this time slot—is really a very small part of Medicare. Frankly, it's one of the largest growing sectors of the program, but it still comprises only about two and a half percent of total Medicare dollars. We have seen a phenomenal expansion in this field from 1980 to 1983. We now have nearly 5,500 home health-care agencies. About three-fourths of them are proprietary and about one-fourth are hospital-based. But I believe that balance will change as the hospitals diversify and establish or acquire comparable home health care and skilled-nursing facilities, in order to give continuity of care.

Home health care is frequently confusing. Deliberately designed as an acute-care benefit, it is limited to intermittent care and to care for the home-bound. As the system has grown, we find that we are currently paying some very interesting amounts of money per visit. And the number of visits *per patient* appears to be growing at a rate of 18 to 20 percent a year. For example, we're averaging about $60 for a home visit by a registered nurse; about $80 for a home visit by a medical social worker; and about $40 for a home visit by a maid. We believe that we have to redesign that system. We're collecting data right now to cluster those services so that we don't have continuing es-

calation in the number of services that are performed.

We are now developing some demonstration projects to do just that. Again, we are trying to decide: do we pay on a total episode basis, do we pay as part of the hospital bill, or do we pay on a per-week basis? We will be testing a number of variations.

Skilled-nursing facilities are another aspect of acute care worthy of our study. The average covered benefit consists of about a 25-day stay. Last but not least is the whole area of physician reimbursement. Twenty-four percent of our total dollar outlay goes to physicians. That area, too, has been growing at the rather rapid rate of roughly 20 percent a year. About 44 percent of that growth results from increased utilization of services, and about 40 percent represents inflation. The rest is due to increased growth in our aging population.

We have a report due in July which studied the advisability and feasibility of utilizing a general DRG payment system for physicians, perhaps paying them for inpatient hospital care under a DRG system.

Other alternatives need to be looked at. Should a fee schedule using a relative value scale be set? That would answer some problems for those who believe there are inequities within the system which need to be addressed. But how would you control the volume of services?

The data strongly indicate that if you compare how closely the medical and surgical sides of hospital care correlate with that of the physicians, it probably is feasible. But the more interesting question concerns advisability? Sixty-four percent of the total dollars going to physicians pay for inpatient care. If you reform patient payments only, do you leave the rest as it is now? Probably not. Because that doesn't do what needs to be done in terms of total structural reimbursement reform.

Other alternatives need to be looked at. Should a fee schedule using a relative value scale be set? That would answer some problems for those who believe there are inequities within the system which need to be addressed. But how would you control the volume of services? Or is the lesson we learned from hospital payment that we don't *need* any volume controls? That's one area still being debated.

Alternatively, if you think about the concepts of prospectivity and clustering, is there a way to cluster physician payments? Should we consider a geographic capitation system for Part B services only? Would we do that to the hospital/medical group combined or to some kind of IPA's, and—just how would that look?

Obviously we need some demonstration projects to look at these alternatives. I think it's fair to say that the total reform of physician reimbursement isn't going to occur this year. But demonstrations will probably begin this fall.

I would not be so naive as to stand here and tell you that it will take many years before some kind of physician reform occurs. Because if there's one thing we learned from our experience with demonstrations in hospices and HMO's, it's that Congress is inclined to take those demonstrations before we finish them, and proceed to implement the whole idea. But I think there will probably be several years of debate before we actually see total physician reimbursement reform.

But keep in mind that other alternative delivery systems are alive and running. For example, we anticipate that as a result of new regulations to pay for better care under the HMO option, the HMO sector will grow significantly. We expect that the Medicare HMO population will double this year, from 300,000 beneficiaries to at least 600,000. We have seen enormous interest from a wide variety of hospitals, multi-hospital corporations and physician groups to line up for approval to develop HMO's and competitive medical plans. In the future we will continue to see that area grow.

We see more and more acute-care facilities diversifying and becoming all-purpose health-care centers. You may well see four, five or six revenue streams coming in under a prepaid concept of a known budget, a risk-reward system and clustering.

If you add to that skilled-nursing facilities, home health care, acute hospital services and clinic visits, at some point in the future whoever is managing that system is going to throw up his hands and say "For heaven's sake, it would be easier if I could have one payment for everything. Give me one capitated rate and I will manage this whole system." And at that point we will move into a vouchered system.

Enhancing competition is an important part of all of this, and we see that going on right now. In the hospital industry, you can use all kinds of interesting marketing ideas, but the best marketing tool is quality of care, because you will not continue to have patients returning if you do not maintain that high quality of care. Our major objective will be to maintain access to high quality care, while slowing the inflation rate. We want to insure that when you and I need Medicare, it will be there intact, an integral part of our scheme for meeting the health-care needs of the elderly.

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UWE REINHARDT

Redeployment of America's Health Resources: Which Direction?

The American health-care sector today finds itself in the midst of a revolution that has cast health-care providers and policymakers onto opposite sides of a battle line.

Providers believe that policymakers seek to constrain health-care expenditures without any regard to the quality of care. Policymakers, on the other hand, believe that the providers' manifest concern over quality is just a smokescreen put up to defend a habit of reckless spending, and opulent lifestyles, without regard to economic efficiency. At the moment there are recriminations all around and nary an attempt at constructive dialogue.

The current battle follows a decade or two of dreams and delusions during which both parties to the fray seem to have believed sincerely that a nation which defied the laws of gravity to go to the moon could also defy the most fundamental laws of economics. We thought health care could be distributed fairly without any form of rationing.

If one were to describe the thrust of American health policy during the past two decades, one would say that Americans sought to develop in those decades a health care system that would simultaneously obviate several needs: to ration health care by price and patients' ability to pay; to ration health care by queue; to ration health care by administrative decree; and to influence the behavior of patients and health care providers through government regulation. It would also encourage the development of technological advances in medicine and their rapid diffusion in health care and encourage patients and providers to use health care resources efficiently.

The current battle follows a decade or two of dreams and delusions during which both parties to the fray seem to have believed sincerely that a nation which defied the laws of gravity to go to the moon could also defy the most fundamental laws of economics.

In reality, of course, that wish list was never fully achieved. There always was some rationing by price and ability to pay; there always was some rationing by queue; and there always was some sporadic, faint-hearted government regulation. The point is that none of these were ever viewed as acceptable—particularly government regulation—and that the search continued for the perfect system.

To anyone familiar with the rudiments of economics, this wish list appears both touching and troubling. It is touching because it seems so exuberantly well-intentioned. It is troubling because it adds up to an act of self-delusion. That delusion has been that the nation could sidestep the need to ration health care by one means or the other.

Grand delusions of this sort inevitably evoke rancor when reality finally intrudes upon them. In the present instance, that reality is a health-care system that is one of the most expensive in the world. At its best, it also may be unrivaled in the world in terms of effectiveness, but for the bottom fringe of our nation's income distribution, it is increasingly a system to which they have no access. The result is that American health care is beginning to generate disgraceful vignettes. For example, a woman enters a private hospital to give birth. In the delivery room, she mentions to her doctor that her husband has recently lost his job and with it, his health insurance. Whereupon the doctor sends her—*in mid-labor*—to the county hospital catering to the area's poorer residents.

In another instance, a public clinic refers a desperately ill baby to a regional medical center for treatment. The baby's parents are indigents and have no family doctor. After waiting in the medical center's emergency room for four hours, the baby is finally admitted by a radiologist. The pediatrician on call had refused to treat the baby on the grounds that he did not want to serve as a back-up for a "free clinic." The baby dies a few hours after admission.

According to the *New England Journal of Medicine*, a 35-year-old woman sustains massive trauma in an automobile accident. A primary-care physician stabilizes her and seeks to refer her to the care of a neurosurgeon at the tertiary care center of a privately endowed university. When the neurosurgeon hears that the patient has no insurance coverage, he refuses to accept the transfer, because he had previously gotten

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Unlike most other nations in the industrialized world, we have not yet reached a consensus on the ethical precepts to be imposed on the distribution of health care among members of society. Unfortunately, to this day we have not even mustered the courage to discuss that troublesome issue in open debate, presumably because it is so delicate. And therein lies the confusion and the impotence of this nation's health policy.

into trouble with the hospital administration over his admission of a critically ill, uninsured patient.

According to *Business Week*, a woman is two months pregnant when doctors tell her that complications require surgery. She and her husband, who earns $9,600 a year at a fire-service center, do not have the $500 down-payment that uninsured patients must make prior to admission at the nearby hospital. A month passes before the money is raised. In the meantime, the woman bleeds internally and suffers a great deal of pain.

According to the *Wall Street Journal*, a pediatrician in a Rock Hill, South Carolina hospital wants to transfer a comatose three-year-old girl to a better-equipped urban medical center. But her family has no health insurance, and two hospitals refuse to take her. A hospital 100 miles away finally accepts her.

Ironically, these vignettes emerge against the backdrop of widespread excess capacity in the health-care sector. In response to a physician shortage perceived during the 1950's and 1960's, the nation more than doubled the capacity of its medical schools and encouraged the immigration of thousands of foreign-trained medical graduates. At present we are abundantly supplied with physicians, and it is generally agreed that there will be an outright surplus of physicians during the 1990's. There is, in addition, a nationwide surplus of hospital beds. Indeed, it is not inconceivable that on the same day and in the same city, parallel conferences might be held, with the following titles: Rationing of health resources and the quality of health care; the physician surplus and its implications for the quality of health care; and the problem of excess capacity in the hospital sector.

How has a nation that prides itself on "Yankee ingenuity" come to find itself facing the necessity of rationing resources of which it has too many? The problem seems perplexing if one assumes that the nation wishes to distribute these resources on the basis of medical need. On relaxing that assumption, it becomes perfectly understandable that a nation may worry, simultaneously, about the impact of rationing and the impact of surplus capacity in health care. The two impacts occur on different positions of the nation's income distribution. We are about to curtail the access of poor and near-poor persons to health care. Their health status may suffer thereby. The owners of the resources freed in this manner, however, are sure to redeploy them in order to earn an income with them elsewhere. The "elsewhere" will be the upper reaches of the nation's income distribution. Individuals in that part of the distribution may be overserved by health-care providers—they may fall victim to needless surgery, for example—and their health status may suffer thereby as well; hence the worry about the impact of a physician surplus on the quality of patient care.

Viewed in this light, then, our dilemma in health care is not primarily an economic one. It is, in essence, a moral one. Unlike most other nations in the industrialized world, we have not yet reached a consensus on the ethical precepts to be imposed on the distribution of health care among members of society. Unfortunately, to this day we have not even mustered the courage to discuss that troublesome issue in open debate, presumably because it is so delicate. And therein lies the confusion and the impotence of this nation's health policy.

The American wish list set forth above can be distilled into three distinct goals for a nation's health system: that the health system provide all citizens "equal access", that the providers of health services be free from government interference into decisions about producing and delivering health services, and how to price these services; and that there be budgetary control over health care expenditures.

Three major prototypes of systems address these goals: the health-care provider's dream world; a national health insurance system with fee schedules and other utilization review; and a price-competitive market system.

Regardless of the system prototype, one can attain any two of these goals in their purity, but not all three. We are forced to choose pairs of these goals, or we must be content with imperfect attainment of all three. For example, we could muddle through by allowing some degree of inequity in access, and by constraining to some degree the freedom in pricing and in the practice of medicine.

Most industrialized nations of the world, such as Canada and West Germany, have tended towards a national insurance system with fee schedules and other utilization review. They have put a high premium on what they refer to as "solidarity". In the context of health care, this term implies that there be health care of a politi-

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cally-determined level of quality available to all citizens on dignified terms, that is, access to health care is a basic right, regardless of ability to pay.

To pursue this goal *and* to exercise control over health-care expenditures, these societies have found it necessary to constrain at least the *economic* decisions of health care providers, and sometimes even their *medical* decisions. In neighboring Canada, for example, physicians are bound to predetermined, negotiated fee schedules, and hospitals must operate within predetermined, overall budgets. Within these constraints, however, both types of providers are free to practice medicine as they see fit. By contrast, in England and in several Scandinavian countries there are, in addition, direct constraints on the style of medical practice.

Because of the constraints these nations place upon their health-care providers, they have been able to guarantee every individual access to a broad range of health services, spending a much smaller percentage of their gross national product on health care than does the United States: approximately six percent in England, eight in Canada and France, and nine and a half in West Germany. America's percentage is now close to 11.

To pursue this goal and to exercise control over health care expenditures, these societies have found it necessary to constrain at least the economic decisions of health care providers, and sometimes even their medical decisions.

It must be added that in almost all countries with national health insurance, a small fraction—usually of well-to-do individuals—opt out of the nationalized system to procure health care on a private basis. In the United Kingdom, for example, about 5 percent of the population chose that route. The percentages are similar in West Germany, in France and in the Scandinavian countries. In Canada the percentage is minuscule. By and large, then, it is accurate to say that for the overwhelming majority (usually more than 90 percent of the population), countries with national health insurance systems guarantee that majority access to a one-tier health system as a matter of basic right, and without any regard to ability to pay. The problem of "uncompensated indigent care" simply does not arise.

It must also be added that nations with national health insurance systems have found it necessary to encrust their systems with fairly rigid codes. In contrast to the United States, where innovation in the delivery of health care is the order of the day, these nations can hardly be said to be innovative in the organization of health services. The high degree of egalitarianism they espouse does come at a price. That price may even include lower *clinical* quality of health care, as American observers are wont to argue—although that belief is not universally shared. West German physicians, for example, claim for their own the title of "best health-care system in the world."

During the decades following World War II, repeated attempts were made to introduce a national health insurance system in the United States. These attempts failed. The American people were warned by health-care providers—physicians prominent among them—that national health insurance represented "socialized medicine" and would inevitably lead to expensive, low-quality care. Many other commentators, health-economists prominent among them, concurred with this prognosis. "If you like our postal system," they argued, "you'll just love National Health Insurance." So far, this line of reasoning has carried the day in this country's political arena and, for better or for worse, it will continue to carry the day for at least the remainder of this decade, if not this century.

An objective policy analyst cannot naysay such a social choice, as long as its consequences are clearly recognized and accepted. But are they? One suspects that health economists arguing against national health insurance knew full well that tacitly they were advocating a two- or multi-tiered system in which health care would be rationed at least in part by patients' ability to pay. Economists have no problem with such a world because they deem it efficient and, one suspects, because they tend to fare well in it themselves. But did our health care providers fully appreciate the implications of their own political rhetoric?

Judging by that rhetoric—"the best health care for all Americans," and so on—it would appear that providers sincerely believed in the feasibility of a paradisical dreamworld in which physicians, hospitals, and patients would be free to select the treatment for a given medical condition, leaving it to someone else tactfully to pick up the tab, without ever raising a question about the composition of that treatment or the prices charged for the services going into that treatment. To raise questions about either the treatment or its cost, it was held, would be an intolerable intrusion of bureaucrats into the patient-provider relationship. It was deemed un-American. In other words, American health-care providers appear to have persuaded themselves

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The United States is virtually the only country in the world in which the individual physician is still free to set his or her fees at will, on a patient-by-patient basis, subject only to the constraint of the marketplace.

and their allies in sundry legislatures, that one could actually extract a perfectly egalitarian distribution of health services from a perfectly libertarian production system?

And libertarian that system has been, the perennial laments by health-care providers over government regulation notwithstanding. For example, the United States is virtually the only country in the world in which the individual physician is still free to set his or her fees at will, on a patient-by-patient basis, subject only to the constraint of the marketplace. Not surprisingly, the fees charged by American physicians are high. On average, physicians in Canada are paid only about a third of the fees customary in the United States for similar procedures. Our system not only encourages the massive application of *real resources* to those medical cases it accepts for treatment. It also makes rather generous *money transfers* per unit of real resource—for example, per hour of physician time—to the owners of these real resources.

By international standards, the American hospital, too, has been remarkably unfettered. In most other countries, the individual hospital is subject to fairly strict regional planning, and its revenues are constrained *ex ante* through fixed *per diem* rates or prospective global budgets. In global budgeting, the hospital manager is free to allocate funds to live items. No other country has been content to reimburse hospitals on a passive, full-cost retrospective basis, as has been the case in the United States until the recent introduction of some private and public payer contracts. To be sure, we have seen some feeble attempts to regulate capital formation in the hospital sector, or to disallow certain hospital charges for reimbursement. By and large, however, one would not be too far off in describing the social contract with American health-care providers over the past couple of decades in these terms: to the extent that health services were insured, third-party payers, both private and public, told providers to do for the patient whatever they deemed appropriate and, thereafter, to go to a collective insurance treasury, there to scoop up whatever monetary reward they, the providers, deemed "customary" and "reasonable."

That this arrangement turned out to be expensive should surprise none but the hopelessly naive. Indeed, what may surprise one is that the arrangement did not cost more! One need only imagine what regular businesses or, say, investment banks would have done had they been issued a key to sundry collective treasuries. (We can get a clue by observing the behavior of defense contractors.) What, one may ask, stopped the system from going through the roof altogether?

One explanation might be that our health-care providers truly have been reasonable—that they were driven by other than pecuniary motives and this saved the treasury from earlier exhaustion. An equally and perhaps more compelling answer, however, is that long before health care expenditures had a chance really to go through the roof, parts of the American health-care sector veered from the paradisical straight down into the market approach. Even during the heyday of the Great Society, the United States never did depart fully from rationing health care by price and private household budgets, as other nations had done long before. In fact, Americans are far less extensively insured for health care expenditures than is widely supposed.

Only hospital services are more or less fully insured in the United States. But hospital services constitute slightly less than half of total national health-care expenditures. By contrast, ambulatory physician services are rather poorly insured. On average, patients appear to pay about 60 percent of expenditures on ambulatory physician services directly out of pocket. Dental care, prescription drugs and other health services are even less well covered. Overall, American patients still pay for about a third of their health care directly out of pocket at point of service. Thus, it is simply not correct to assert that price no longer plays a role in the distribution of health services in the United States.

Many Americans have no health insurance coverage whatsoever. The actual number of such persons tends to fluctuate over time with economic conditions, for it is a feature of our economic order that employees who lose their jobs typically lose their health insurance coverage as well. As a rule of thumb, however, one can say that roughly 10 to 12 percent of the American population—between 22–25 million people—are without any health insurance coverage at any point in time. Most of the uninsured belong to low-income households.

As poor, uninsured persons have fallen seriously ill we have not, of course, let them languish in our streets. Usually we have treated them, whereupon we have tried to recover the cost of their treatment first from them and, failing that, from other

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paying patients via a process known to health-care providers as "cost shifting." A distinguishing feature of this approach—one that separates the United States from virtually all other nations on earth—is that the uninsured receive such care in the form of unpredictable *noblesse oblige* on the part of some provider, rather than as a matter of entitlement. Depending upon one's social ethics, one may or may not judge access to health care on these terms "dignified." In any event, the very nature of this *noblesse oblige* is apt to have acted as a rationing mechanism in American health care.

The peculiar and uniquely American approach to indigent care was kept ethically bearable as long as the reimbursement system for paying patients was so open-ended that the cost of treating the insured poor could easily be passed on to the paying patients. This now much-maligned process of "cost shifting" actually served as the fig-leaf that covered up what would have otherwise revealed itself to the world as a national disgrace.

The days of passive, full-cost retrospective reimbursement for hospital services and of "usual, customary and reasonable" compensation of physicians are numbered.

The fig-leaf, alas, appears to be slipping. It is being dislodged by the price-competitive pressures now beginning to manifest themselves in American health care. The days of passive, full-cost retrospective reimbursement for hospital services and of "usual, customary and reasonable" (UCR) compensation of physicians are numbered. Gone are the times when Americans trusted health-care providers so freely with the nation's resources.

Starting in October 1983, Medicare began to compensate hospitals at prospectively set, nationwide, administered prices per medical case on a take-it or leave-it basis. It is a safe bet that, also before long, that program will scrap the time-hallowed UCR system and compensate physicians on the basis of fixed fee schedules or even on the basis of medical cases. It is possible that the DRG system for hospital care will eventually give way to an alternative, simpler method of compensating hospitals—perhaps to predetermined per-diems or even to global budgets. In any event, it is a safe bet that any such system will be prospective and based on regional averages that abstract from the individual hospital's own cost experience.

It must be expected that the private health insurance sector will follow suit in this reimbursement reform. After all, behind that sector stands the business community which now absorbs about $100 billion annually in health-care expenditures through employer-paid health insurance premiums for employees. Until very recently, corporate managers had paid scant attention to this type of expenditure. It was therefore quite easy to pass most of the cost of treating uninsured indigents through to the business community's payroll account via commercial health insurance premiums. For this type of cost shifting the days seem numbered as well. More and more businesses now actively seek to extract price concessions from health-care providers through arrangements known as Preferred Provider Organizations (PPO's). Under these arrangements, employees are steered, through financial incentives, toward "preferred" providers who have agreed to make price concessions and, typically also, to exercise economy in the prescription of medical procedures.

Where PPO's fail to yield the desired economies, the business sector can always resort to the ultimate weapon in its cost-containment arsenal: contracts with Health Maintenance Organizations (HMOs), under which the HMO agrees to deliver comprehensive health services in exchange for a flat prepaid annual fee per patient at risk. Under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, prepaid contracts with HMOs were legitimized for the federal Medicare program as well. Where such an approach is based on price-competitive bids among competing HMOs in a given area, it constitutes the ultimate flexing of market-muscles by the purchasers of health services.

Whatever the particular acronyms in the "medical alphabet soup," their objective is always the same: so-called "prudent purchasers" of health services with market power seek to extract price concessions from providers so that the prices paid are above incremental cost but below fully allocated costs. The name of the game is to convert the payment for *all* health services—not just the cost of indigent care—into a hot potato, so to speak, which is passed on from one payer to the other through the process of "price discrimination" (a.k.a. "cost shifting").

Price discrimination is a strategy by which payment for the fixed costs (and profits) of producing a good or service is extracted predominantly from those purchasers who are unable to resist higher prices. It is a strategy of "greasing the wheel that squeaks the loudest and of plucking the goose that squeaks the least," so to speak. Such a policy is a natural tea-

ture of a price-competitive market in which the fixed costs of producers are high in relation to variable costs—even if only in the short run—and in which consumers cannot resell the services produced. Airlines and hotels widely practice this pricing strategy. It will be a prevalent feature of American health care in the future.

Because there must be a limit to the ability of even weak purchasers of health care to absorb costs shifted their way, however, collectively the purchasers of health care clearly seem bent on transferring fewer dollars from the rest of society to health care providers as a group, leaving the providers to fight among themselves for their share of the reduced, aggregate transfer. It is not a pastoral world, and not one in which nice providers necessarily finish first. Furthermore, the game is bound to squeeze out the erstwhile cross-subsidies by which paying patients were made to cover the cost of treating indigent patients and by which American society assumed the appearance of decency.

Having led the good fight against "socialized medicine" for three long decades, our providers of health care seem to have backed into that meat grinder otherwise known as the price-competitive health care market.

The irony inherent in this development is not easily overlooked. Having led the good fight against "socialized medicine" for three long decades, our providers of health care seem to have backed into that meat grinder otherwise known as the price-competitive health care market. It is a new world, one in which health services are "product lines," and health care providers are forced to behave like regular commercial enterprises merely to survive. Physicians, in particular, seem to be bewildered and alarmed by this turn of events, for they are learning quickly the general definition of a competitive market: it is an arrangement whereby the provider's life is made tough so that consumers can live comfortably and cheaply. But what else did physicians expect when they fought national health insurance?

We have now driven the cost of health care to the point at which we are reluctant to purchase that expensive commodity for our poorer brethren. Providers have contributed to this outcome by the rhetorical arsenal they have deployed in the political arena. In the face of any proposal to control the cost of health care, providers have tended to hurl across the appropriate legislative chamber two concepts to have our policymakers run for cover. These verbal projectiles were "the quality of patient care" and "two-tier health care."

Cost control, it was argued, would inevitably reduce the quality of patient care. Wealthy Americans would use money to bribe their way around cost-control barriers to high-quality care. Consequently, only the poor would put up with the constrained lower-quality tier. Since two-tier health care is un-American, went the final blow, clearly so must be cost containment. Far better, argued our health-care providers, to keep the system open and affordable through "voluntary cost-containment efforts" on their part. Utterly persuaded by this line of reasoning, Congress bought "voluntary efforts" of various sorts, and also appropriated even larger sums of tax monies to pay for the system.

For over a decade, these rhetorical weapons reigned supreme, devastating even the feeblest attempt at cost containment. In the hard-nosed climate of the 1980s, however, the themes from the 1970s are losing their punch. Rather than simply hurling such slogans at the legislators' viscera, our providers now had better learn to discourse *intelligently* about terms such as "quality" and "two-tier health care," lest their concerns in this area be overlooked altogether. After all, thoughtful persons have long appreciated that there is no tight link between health-care expenditures and the quality of a health-care system.

As already noted, in thinking about the "cost of health care" a distinction must be made between the real resource costs of treating patients and the monetary transfers occasioned by the treatment. The real resource costs of a treatment consist of time physicians and other health workers devote to it, and of supplies, equipment, brick and mortar used up in the process. The monetary costs are measured by the amount of money patients directly or indirectly funnel to the owners of these real resources. Clearly, these monetary costs can rise without a commensurate increase in real resource costs. For example, if a cardiac surgeon decides to raise his or her fee for a coronary bypass from $5,000 to $8,000, only the monetary costs of the treatment rise; its real resource cost does not. This important distinction seems not always as well understood as it should be in debates on health policy.

If a cost-containment measure is sought to reduce expenditures on coronary bypasses, the first step might be to roll back the physician's fee from $8,000 to $5,000. The physician's immediate response might well be that the "quality of patient care" will suffer, just as the American Medical Association has recently argued that the

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fee-freeze imposed by Medicare "has forced the nation into a two-tier system of medical care in which Medicare patients have become 'second class citizens.'" What precisely is the public being told here about the professional ethics of American medicine?

Is it the thrust of this argument that, for a mere $5,000 per coronary bypass, the physician will do a sloppier job than for $8,000? Or is it the point that the physician will henceforth reject any patient who cannot come up with the desired $8,000 in cash and that the patient will thereby be deprived of the physician's (presumably superior) skill? This question is raised here not so much to nettle as to alert the authors of such statements to the dubious image they project thereby: it is the image of a profession that needs to be rewarded with cold cash for every bit of good it does, and whose professional ethic has a monetary price! Far better to argue that a constraint on physician fees violates principles of a free society, or that prevailing fees under Medicare are low relative to, say, the fees paid to bond lawyers for their simple, routine work.

Let us, next, go beyond mere monetary transfers per unit of health services to the real-resource input per medical case treated. Can we take it for granted that any reduction in the real-resource input of medical treatment necessarily entails a reduction in the quality of care? That there may be such a consequence can be taken for granted. But will it necessarily be so?

For most medical cases, the relationship between quality and cost probably traces out a backward-bending curve. By "clinical quality" in this context we might mean, for example, the probability of recuperating from the condition to a given degree. It can be thought that, up to a point, increasing resource inputs (for example, diagnostic procedures) will increase the "clinical quality" of care, albeit at a diminishing rate of increase. Eventually, however, there must come a point at which further expenditures in resource costs cannot yield further increments in "clinical quality." Costs have increased without adding to the "clinical quality" of care. There may even come a point at which further resource-input harms the patient.

There must come a point at which further expenditures in resource costs cannot yield further increments in "clinical quality." There may even come a point at which further resource-input harms the patient.

Let us assume that the cost-quality trade-off curve had been pushed to the maximum attainable level of clinical quality. We might then raise the following two questions in connection with the argument that cost containment inevitably implies a diminution in the "quality of patient care." Is it alleged by those who make this case that our health system never did expand beyond a point of trivial or zero marginal returns? Even if that were so, would reduction in quality necessarily be unethical?

Health care is a commodity whose technical quality is not easily assessed by patients. Furthermore, as noted, the cost of some types of health services—for example, hospital care—is quite well insured for most Americans. Finally, it is the case that our health system is increasingly beset by the excess hospital capacity and by a surplus of physicians. Under these circumstances, an increase in the real resource costs of treatment can certainly not be ruled out "a priori". Because one person's health care expenditure is always some provider's health care income, such a move can enhance the provider's quality of life even if it does nothing to enhance the clinical quality of the care received by patients. One need not be a misanthrope to believe that fiscally hard-pressed providers will be responsive to this economic opportunity. One need merely assume that, like everybody else, health-care providers are human.

That this assumption is widely shared in the United States can be inferred from the ever increasing popularity of prepaid capitation for comprehensive health services, an approach that has found favor not only among legislators but also in the American business community. Whatever polite introduction the advocates of prepaid capitation may give to that approach, they clearly are persuaded that the financial rewards providers derive from composing medical treatments strongly influences that composition—that our health-care system has reached a maximum in clinical quality but the real resource costs of treatment have increased.

Let us now turn to the question whether it is ever ethically acceptable to reduce health care expenditures when such actions demonstrably lower the "clinical quality" of care. Concretely, such a move might mean that one permits increases in the number of deaths per 100,000 admissions for a given illness merely to save money.

Actually, as individual consumers and as a body politic, we constantly make trade-offs of this sort, without any ethical pangs. As consumers, for example, we might opt for small cars to save money even if that increases our risk of injury or death in trat-

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tic accidents. Similarly, our legislative bodies routinely refuse funds for projects that might save lives. For example, a town council might vote against outlays for better street lighting fully aware that a number of traffic fatalities could eventually be attributed to that vote. One could even imagine that, on balance, additional lives would be saved if funds were reallocated from the town's hospital to its road department.

Health-care providers find it difficult to apply that line of reasoning to their own context, and for good reasons. First, they are expressly trained to fight at all costs for their patients' lives. Second, while detached policy analysts may find it easy to discourse from a safe distance upon the value of life, no one has yet given the individual physician a publicly sanctioned set of guidelines under which to make cost-quality tradeoffs at the patient's bedside. So far, society has delicately preferred to leave that matter to the physician's own conscience and judgment. In other words, physicians can legitimately claim that, while they are perfectly capable, intellectually, of following the economist's stylized illustrations of trade-offs between lives saved on the highways and lives saved in the hospital, as physicians they really do not know how to act on these illustrations at the patient's bedside. As policy analysts we should, perhaps, admit that our exhortations on these tradeoffs have not been particularly well thought out.

It is one thing to explain to patients that they cannot have a particular procedure because there just is not the equipment with which to perform it. It is quite another to deny the procedure within sight of unused equipment and strictly appeal to someone's money budget.

The providers of health care must reckon with the prospect that society will increasingly both flagellate them over health-care costs and saddle them with ethical dilemmas no politician (and possibly not even most economists) would have the courage to face in the trenches. With their votes in federal, state and local elections, American taxpayers seem to be signalling more clearly than ever before that they do not wish to be their poorer brethren's (financial) keepers. They would prefer health care providers to fill that role, as the providers have in the past, and they (or the media) stand ready to complain whenever a provider fails in that role. Unfortunately, no one seems to have figured out how providers can act on noble sentiments without explicit compensation for their labors. So far, we have left that problem to the providers as well.

Americans often express misgivings over the rationing of health care in other nations, particularly in Great Britain. It is always pointed out that rationing of this sort is the inevitable outcome of "socialized medicine."

Rationing in Great Britain proceeds in two stages. The first stage is a political consensus on the overall resources constraint to be imposed upon the health-care sector. That political decision determines the physical capacity available for health care. The second stage of rationing occurs at the level of medical practice. As the process is described by Henry J. Aaron and William B. Schwartz in their 1983 book, *The Painful Prescription: Rationing Hospital Care*, the allocation of scarce physical resources to patients is made by the medical profession. By and large, that allocation seems to have the respect of the populace.

Rationing of health care in the United States is of a quite different variety, because it grows out of a quite different approach to resource allocations. Physical resources, including manpower, can flow freely into our health sector. Furthermore, their owners enjoy a high degree of freedom to deploy their resources as they see fit. As we noted earlier, the flow of these resources has been vigorous, particularly during the decades in which this nation flirted with the costly idea of extracting an egalitarian distribution of health care from its libertarian delivery system. Because health care is now so expensive, we face the problem of rationing access to health resources that are in abundance, if not in surplus. It is one thing to explain to patients that they cannot have a particular procedure because there just is not the equipment with which to perform it. It is quite another to deny the procedure within sight of unused equipment and strictly appeal to someone's money budget. One might call it rationing of a higher order—"higher order" because its implementation in the trenches requires a special kind of fortitude.

These two different styles of rationing grow out of two fundamentally different perceptions of the role of health care in a society.

In Canada and the European nations, health care tends to be viewed as a community service whose provision and financing are ultimately the responsibility of the public sector. Access to health care is granted each citizen as a matter of right, to foster the sense of solidarity these nations consider an essential cornerstone of nationhood. To that end, the financing of health care is completely divorced from actuarial principles. The individual's financial contribution to health care is strictly a function of

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It would be more accurate to say that health care is now viewed in this country as a private consumption good whose financing is ultimately the responsibility of the individual.

his or her ability and not at all of his or her health status.

As noted, during the 1960s and 1970s, Americans seemed to be veering toward this perception of health care as well, albeit ever so gingerly. Emerging from World War II with the rightly earned self-image of "the most generous people on earth"—a perception that, remarkably, lingers to this day—it was thought that such a people should naturally grant every citizen access to "the best health care in the world."

Few students of this nation would impute that goal to Americans today. It would be more accurate to say that health care is now viewed in this country as a private consumption good whose financing is ultimately the responsibility of the individual. Indeed, when healthy, well-heeled Americans yearn for "actuarially fair" health insurance premiums, they are really communicating that they do not wish to subsidize their poorer, sick brethren through those premiums. Furthermore, with their votes they signal that they are not inclined to replace through taxes the subsidies they are unwilling to provide through insurance. We may still be "the most generous people on earth," but perhaps just not in this area.

The first step towards a more rational—and more humane—health policy would be to acknowledge the emerging social ethic openly and to take it as a given, at least for the time being. The best that the poor and their champions could hope for at this stage would be a system of two-class medicine, one for those relying on public financing, and another (or several other classes) for everyone else. Before long, the receipt of numerous novel medical procedures will be tantamount (in cost) to the acquisition of a small BMW, if not a large Mercedes Benz. While the nation's well-to-do will certainly wish to have access to such care, and to pay for it with actuarially fair health insurance premiums, it can be doubted that they will routinely wish to bestow "Mercedes" of this kind upon perfect strangers whose very poverty raises questions about their social worth in the first place.

A more realistic assumption would be that Americans will wish to treat health care like certain other basic commodities, such as food, clothing and shelter. American society has sought to make basic quantities of the latter available to all of its citizens, but there has never been an attempt to distribute them on an egalitarian basis. Instead, the nation has adopted for them a so-called "basic-needs approach." Even during the heyday of the liberal 1970's, we tacitly adopted the basic-needs approach for health care as well. The poor might have fared better, however, if we had mustered the courage to acknowledge that ethical precept openly and to base our policies upon it.

In the future, our manifest preference for the basic-needs approach in health care will reflect itself in the development of two or several tracks of health care.

At one end of the spectrum, there will emerge expensive, luxurious health-care complexes indistinguishable in many respects from luxury resorts. These complexes would be able to attract first-rate medical personnel, just as the nation's prestigious private universities—which also cater disproportionately to the offspring of the well-to-do—tend to attract first-rate scientists. There will be hospitals with exquisite atriums, with gourmet foods, personalized services and all of the other good things America's well-to-do enjoy elsewhere in life. We may think of this end of the spectrum as "designer care" or, to use Marion Ein Lewin's marvellous term, "boutique medicine."

At the other end of the spectrum there will emerge closed-panel delivery systems which in effect will ration health care through limits on physical capacity, just as the British National Health Service does. These systems will deliver comprehensive health services in exchange for prepaid capitation which has either been negotiated or determined by competitive bid. In principle these systems need not give health care of inferior "clinical quality"; they may just lack certain amenities, including the privilege of free choice of physician or hospital. In practice, of course, some of these systems may represent decidedly second-class medicine, particularly if they are run by unscrupulous operators, or if they are seriously underfunded, as at least some are bound to be.

From the perspective of the nation's poor, this choice- and resource-constrained lower tier might represent a decided advantage over the current two-tier system. To the extent that, through application of its considerable market power as purchaser, the public sector could keep the cost per capita of the lower tier reasonably low, society might see fit to grant, at long last, every American guaranteed access to at least this tier as a matter of right. As noted, under the present two-tier system such access is more properly described as unpre-

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dictable "noblesse oblige" on the part of the providers. Access to at least something as a matter of right would imply a measure of dignity now absent from our health system. As an erstwhile pauper, this author, for one, imputes great value to that measure of dignity.

Second, a resource-constrained bottom tier would permit physicians to ration health care with appeal to limits on physical capacity. It would spare physicians and hospital administrators the need to deny care to patients within sight of idle resources, merely to defend someone else's budget. Idle capacity elsewhere in the system may not bother the poor if they do not see it. We might just get away with it.

Depending upon one's own social ethics, such a multi-tiered health system may or may not be perceived of as close to the ideal. It does seem close to the dominant social ethic of the day, however, and therein would lie its virtue.

Physicians in particular may balk at the idea of legitimizing a system of two-class medicine. They may fancy that such a system would violate central tenets of their professional ethic.

Physicians in particular may balk at the idea of legitimizing a system of two-class medicine. They may fancy that such a system would violate central tenets of their professional ethic. But has that ethic ever played a decisive role in American health policy? As noted, the nation spends close to 11 percent of the GNP on health care now. There is a surplus of physicians and of hospital beds. Yet, with these generous money transfers and with these ample physician resources, the health sector has not so far succeeded in granting all Americans dignified access to needed health services. Whatever the medical profession's code of ethics may be, its role in the distribution of health services has been rather feeble all along. It is probably too late to invoke that code now to stem the forces of the market place.

It is customary to end talks of this sort with "viable policy recommendations." Listeners tend to be frustrated when a diagnosis of social problems is not accompanied by a recommended therapy.

To be "viable," a therapy should be acceptable to the patient. In the present instance, the question is just what therapy would be acceptable to the American body politic.

The thrust of the preceding analysis has been that the currently emerging problem in American health care are not driven by a scarcity of resources, but by uncertainty over what constitutes a "just" distribution of plentiful resources among members of society. These problems are a product of the nation's soul. As a nation, we seem unable to decide whether access to acutely needed health care is a citizen's basic right, or whether there merely exists an unenforceable moral obligation on the part of providers to render such care. Indeed, we have not even been able to decide just what level of government should define whatever rights there might be to health care in America.

The latter question touches upon the locus of responsibility for providing the uninspired poor with adequate health care in time of need. Is that a federal responsibility? Or is that fully the responsibility of the state or even the local government? To think about that question, we may ask ourselves whether residents of state "X" should worry about the death of American infants in state "Y." If a North Dakotan should care about the health of American infants in, say, Arkansas (and vice versa), guarantees of access to adequate health care would seem to be a federal matter. Conversely, the notion that health care for the poor is purely a state and local matter suggests that North Dakotans have no business worrying about what people in Arkansas do or do not do for American infants residing there, and vice versa. To the best of my knowledge, that issue has never been discussed openly in these terms. It should be.

Until such fundamental questions are openly settled we may, of course, continue to tinker with that ever more wondrous Rube Goldberg contraption called American health policy. We may pool a little revenue in some locality for the uninsured poor, and throw a little local tax money at health care providers in others. Such measures would furnish the grist for quite another talk. The objective of the present discussion has been a different one: to explore the nature of the ethical precepts that have driven our health care system in the past and that seem to drive it now. Let the audience judge whether the assessment has been fair and, if so, whether these ethical precepts can serve as a source of national pride.

PETER FARLEY

The New Technology of Genetic Engineering

Certain fundamental new technologies will impact on each and every one of us, both physician and non-physician.

First, considerable fuss has arisen about genetic engineering and how it relates to the treatment of cancer. With genetic engineering, the pharmaceutical industry can now manufacture human proteins. Proteins are basically the functional molecules of the body. But despite years of pharmaceutical research, we still know very little about them. Mostly we know about those proteins that happen to float around in the bloodstream where we can get our hands on them. The body is composed of tens of thousands of functional proteins and they each play an important role in some part of life's processes. If we can clone genes that code for them, and insert those genes into microorganisms for fermentation, then we can theoretically make as large an amount of any natural human protein we desire.

What application does genetic engineering have in the treatment of cancer? Until a few years ago, it was commonly thought that cancer was a relatively infrequent and unfortunate event. It happened perhaps once in a lifetime, if at all. But in the last several years we've learned that cancer occurs to us all with amazing frequency. Dividing cells get out of control, a transformation event occurs and we begin to get what we call cancer, the out-of-control multiplication of cells.

The point is that we're seeing a new world of therapy, a new world of treatment. Not only do we have access to an entirely new pharmacology, but the techniques that will be required to administer it really come from the world of molecular biology and immunology.

But the body has natural defenses against this occurrence. A variety of proteins work in a cascade as part of the immune system to fight cancer. The new developments in gene splicing enable us to identify important proteins and the role they normally play in metabolism and in fighting cancer.

I'm going to walk you through two specific examples, to show you why we are excited about an entirely new pharmacology that's developing, one based on the body's natural defenses. One involves a compound called Interleukin II. Call it IL2, for short.

IL2 is a natural human protein. When the immune system recognizes that a cancer is developing, the signal goes out, and it is then the job of IL2 to activate certain white cells in the body called lymphokine-activated killer cells. In response to the protein activation, these killer cells literally destroy the cancer cells. Work on this IL2 compound has progressed through Phase I at FDA studies, and is now in Phase 2. We're somewhat encouraged, to say the least, by the results.

We're talking here about protein-based therapeutics. At least two dozen such products are working their way through the FDA this very afternoon.

The administration of protein products is going to involve new technology. Indeed, this is true with IL2. If you give the protein intravenously, you get some biological response, but nothing very remarkable. However, if you withdraw a couple of units of blood from the patient, spin down the cells, grow the white cells in tissue culture in roller bottles, keep those cells alive and growing and nurture them with IL2, you get a proliferation of this subset of killer cells. And over a two-week period, the predominant cell in the population is the killer cell. Give these cells back to the patient after the two-week period, and the responses are encouraging. The actual data will be published soon.

The point is not the efficacy of IL2 in particular. The point is that we're seeing a new world of therapy, a new world of treatment. Not only do we have access to an entirely new pharmacology, but the techniques that will be required to administer it really come from the world of molecular biology and immunology. And so I predict we'll see a totally new medical specialty coming into being very quickly, a specialty that includes a facility with tissue culture techniques, histochemistry techniques, protein measurement techniques, growing cells, and others. I think this new specialty will evolve very quickly.

Monoclonal antibodies are another example of protein-based therapeutics

There are a half-dozen working their way through the FDA today. These are specific proteins that will latch onto a specific target molecule and, hopefully, nothing else. The entire scheme is based on how to arm these guided missiles, if you will, with warheads—be they existing drugs, radioactive material or toxins. The task is to find a molecule that sticks specifically to the cancer cell and most definitely does not stick to anything else. What we see here is a new era of custom-tailored pharmaceuticals. What we now know is that there's both an overlap and gaps in the coverage of these molecules, and what adheres to one particular tumor may not bind to a similar tumor type. And so we're going to see a new era of literally custom-tailored drugs based on the biopsy and tissue culture of the individual tumor. Again, most of the techniques are coming out of the world of molecular biology, immunology and histochemistry.

How will this new revolution find its way into our health-care delivery system? There will be some subtle changes, given the overall emphasis in our society of rewarding efficiency. I see the for-profit hospitals, the private sector and the more community-based hospital centers gearing up to develop protocols, handle these compounds, and move them as rapidly as possible through to FDA-approved clinical testing. And I see this happening somewhat apart from the academic world. The pressure that will bring this about is the fact that the government is stepping further and further back from the funding of this sort of work, and the private sector is moving in. It's an interesting nuance. I would predict that we will see free-standing immunocancer centers throughout the country in the next four or five years. So a new specialty and indeed even a new relationship between the for-profit sector of the health care system and the academic centers are possible.

Within the next five to ten years, if cancer begins to come under control due to the new types of therapy available, the 75 to 95-year-old population will suddenly increase even faster than presently forecast.

I think one area that's overlooked is the relationship of the new technology to the aging population. Within the next five to ten years, if cancer begins to come under control due to the new types of therapy available, the 75 to 95-year-old population will suddenly increase even faster than presently forecast. It's already the most rapidly growing segment of the population. But when I look at some of the studies and I see the far end of the growth curve, nowhere do I see any allowance for a sudden increase resulting from a major technological breakthrough bringing a major disease under control. I think this is a challenge for society. The question of housing of the very old, of people requiring ongoing support, for example, is something for which we as a society haven't even begun to prepare. We will probably be surprised at the speed with which the new technology will make an impact.

Another important area of the technologic revolution is the information revolution, that is, computers, telecommunications—information is exploding. And this is a challenge particulary for each and every person in this room. Socioeconomic pressures for change are occurring, and efficiency is the guide word. What we are seeing is "big is better:" doctors grouping themselves together, be it in PPO's, HMO's, or some sort of practice association; not-for-profit hospitals forming alliances; for-profit chains thriving. The general theme through all of this: bigger, bigger, bigger, and bigger seems to be better, because there is efficiency in scale. The life blood that makes all of this work is information.

Information that is collected will be used irrespective of the quality of the information. It will be utilized by people in management positions; by people involved with insurance, that is, the payee's side of the equation; by health-care officials, and so forth. Sooner or later, information that exists will be used. But will it be used properly or will it be misused and abused? I firmly believe that we will move into the development of practice standards, whether locally, regionally or nationally. I realize that practice standards aren't very popular. Be that as it may, they are a fact of life. It's going to happen overnight. Organized medicine has one of two broad choices. You can resist practice standards absolutely, howl to the moon and say "We want to go back to the good old days of a year and a half ago." Or you can say "My God, we are the individuals charged with the ultimate well-being of that patient. And if any of this decision-making, rule-making and standard-setting is going to come into being, we're going to accept that as a practical reality and we're going to *become the agents of change*. We're going to make sure that the patient's best interest is looked after." In the final analysis, that's the job of the professionals in this room.

With genetic engineering and the information revolution ushering in massive change, the times are exciting!

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DAVID JONES

Competition for Scarce Resources: One Example

A major public policy question involving each of you concerns the caring for the poor and disadvantaged in our society. Will there be crowding out in the competition for scarce resources? That is, if money is spent on technology, will it somehow deprive the indigent population of access to health care? The answer is "no," as the following story shows.

University Hospital in Louisville, Kentucky was the hospital of last resort. It treated the poor, and those with no alternative at all. The overdoses, the knifings and the shootings—they went to University Hospital. It was actually quite good as a trauma center, but it was always coming up short in the competition for funds.

The funding was extremely unstable. It was tied to fluctuating government revenues and priorities, and therefore its funding always lagged behind inflation, especially in nurse salaries and technology. As a result, quality declined, and private patients deserted the hospital. Finally, indigent patients themselves were being turned away, despite the fact that $14 million in public subsidy were poured into the hospital in its last year. Throughout that decline, medical education suffered, and there were too few patients, too few resources. Six departmental chairs were vacant. No one would take those positions because the physicians couldn't make a reasonable living.

Every single constituency that had any legitimacy at all in dealing with the question was involved in the eight months of negotiation.

Overall, it was a disaster. And my guess is that many communities, many medical schools and primary teaching hospitals in the country are someplace along that particular curve. Some are in bad shape, some in good shape.

In Louisville, we addressed that problem through innovation and leadership—a strong and intelligent mayor, himself a physician, a strong and intelligent county judge, capable, risk-taking University leadership, and above all a strong and confident governor, willing to seek new solutions.

The state built a new physical facility for the hospital. The University refused to accept it, lacking the funds necessary to open it and to support the anticipated first year loss of $10.5 million. Even in the old hospital, the University was losing $4 million per year with an endowment of only $23 million, whose principal had to be invaded to make good the loss.

To solve his dilemma, the Governor asked for proposals. After six months of private negotiations, one private voluntary hospital group offered to pay one dollar a year rent for the hospital and also to take care of indigent patients, so long as government funding was available. When government funding ran out, the doors would be closed. But, of course, that didn't solve the community's problem.

So a second bid was entered, this time from Humana. Humana offered to pay higher rent for the hospital—$6.5 million instead of one dollar. In addition, we agreed to take care of all the adult indigent residents of Jefferson County. Nobody knows how many there are; the indigent patient is somebody who receives no societal support through Medicare or Medicaid, but who, nonetheless, can't afford needed hospital care. Humana offered to take care of all those people, and in return, the government agreed to maintain their present level of funding for the first year, and thereafter to increase the funding annually by the lesser of tax revenue or consumer price level increases. Humana's absolute commitment is supervised by a public ombudsman having the non-appealable power to require hospital admission in the event of a dispute as to indigency. In 26 months of operation, no such decision has been required.

This story illustrates the point that technology needn't crowd out the indigents. The elegance of the Louisville solution is in its simplicity. And the genius is in having everyone involved. Every single constituency that had any legitimacy at all in dealing with the question was involved in the eight months of negotiation. It was all done in the open. Votes were taken by the medical school faculty, University faculty and trustees, the City County Board of

Health, the Aldermen of the City, the Fiscal Court of County, the State Legislature and the Department for Public Welfare. They all had a say as well. Everything was reported publicly and all the discussions and negotiations were held in public so that anyone who had anything to say about it could do so. A smoothly functioning, affordable model has been created in Louisville. It's probably the only city in America that no longer has an indigent care problem.

Any hospital that receives a patient it doesn't want to accept knows that the patient is welcome at Humana Hospital-University. The reason the patient is welcome is that we have a contract with the government that provides, at no additional cost to government, the resources necessary to take good care of that patient.

The best thing about this particular experience is that it could easily be replicated in any community that has at least one good hospital with open-minded leadership willing to take a risk.

How can we do that in the inflationary era in which we find ourselves? It's very, very simple. The hospital already had some private business, some Medicare and Medicaid business and a whole series of costs that were virtually fixed. Almost every cost that you can think of in the hospital, except for some food, supplies, and medicine, was already there, whether another patient came or not. So when we add the $20 million of revenue from the indigent care contract to the other sources of revenue available to the hospital, and bring all those patients through one very good hospital, the unit cost is lowered for everyone.

In the very first year of operation, the prior year's $4 million loss, which an Ernst & Whinney study had predicted would rise to $10.5 million in the new facility, actually turned out to be a profit of $2.5 million. Twenty percent of that is shared with the medical school, to enable it to enhance the quality of its programs. All of the vacant chairmanships have been filled. For five residency positions in the OB department, 190 applications were received this year. The University trustees had voted for the contract by twenty to one, while the medical faculty was 76 percent in favor of it. There was a fair amount of concern about the affiliation agreement required to carry out this kind of experiment. Although we pay the salaries of the residents, and we pay the costs of maintaining the clinics and so forth, the decisions about who staffs those clinics come from the University. And so there is an intersection at which misunderstanding could occur. All of us had to come with an open mind. The contracts also include a stated conflict-resolution procedure. It's nice to have that procedure in place, although in two years we haven't had to use it.

In closing, I'd like to say that the best thing about this particular experience is that it could easily be replicated in any community that has at least one good hospital with open-minded leadership willing to take a risk. I see this society as having the resources, times ten, to provide universal access and high quality medical care to its citizens. What is needed is the courage to take advantage of the opportunities for innovation which are occurring in our changing environment.

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MICHAEL BROMBERG

Investor-Owned Hospitals: The Resource Crunch

There are only four ways to go with supply and demand. You can increase them or decrease them and three of the four combinations have been tried and failed.

Until recently, health-care rhetoric revolved around the word "cost." We were accustomed to being paid on the basis of "cost." But a couple of years ago, a revolution brought on both by private employers fed up with high costs, and by a government determined to do something about those costs with the enactment of a prospective payment system, shifted the rhetoric to "price," not only of price per unit of service, but of fixed payment per case in the hospital field. I think next year the revolution probably will have gone past this and we will find ourselves talking not about fixed price per illness, but rather of fixed price for total health-care services. That's really an insurance concept, but that is where the health system is heading right now.

This new national policy came about for a number of reasons. In the 1950's, America's national policy revolved around "supply." Increase supply—that was the economic theory. Hill-Burton is the best example we have of it. We decided to give federal grants for hospital construction and modernization. It worked. Hospitals were built when they were needed. But now the program is gone and the funds are gone with it.

Secondly, we increased demand by enacting Medicare and Medicaid in the 1960's. The rhetoric of the times required "more access to more health services for more people, without a means test, with dignity." And it worked. Many people who were not getting health care are now getting it. These programs have been highly successful from an access, and perhaps a quality, point of view. But the costs became too high, and that had to be changed.

Then we tried to control supply. We had increased supply, we had increased demand, and now we did a reversal and we tried—under Nixon and somewhat under Carter—to control supply. The best example is the Certificate of Need. This program was implemented on the economic theory that if we could control supply, costs would go down. It didn't work, because people got around it. You could control the cost of erecting a building, but then the cost of ancillary services went up and total costs really went through the roof. Jimmy Carter even tried price control. Nixon tried price control. But it didn't work.

I think that by the time Reagan came in, there was really no choice left. There are only four ways to go with supply and demand. You can increase them or decrease them and three of the four combinations have been tried and failed. The policy of this Administration became to reduce demand—the only alternative left. How do you reduce demand? There was a four-point program, and the first two points failed: putting a tax ceiling on the amount of insurance people can have, and trying to implement cost sharing. But the other two points succeeded: prospective payment, and encouragement of alternative delivery systems like HMOs. So at least 50 percent of the Reagan program has been enacted into law and the data prove that, at least for the short term, it will work.

Probably the single most historic change in the Medicare law, and perhaps in national health policy, will turn out to be this so-called HMO Competitive Medical Plan Option. I'm going to get back to that in a minute, because I think it is really the wave of the future.

First I'd like to explain why I think we had early success with investor-owned hospitals. Part of the credit goes to our favorable attitudes toward cost reimbursement. But I think the key thing to remember about the investor-owned industry is that we discovered a whole new way of raising capital: the use of the stock market and equity financing. The investor-owned hospital base of 150,000 beds in this country today is worth $20 billion. That's what it would cost to reproduce it in a non-profit mode. That $20 billion did not have to come out of the public sector for construction or modernization. It came out of private financing.

Analogously, it's like private schools. I think public school educators will tell you

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that private schools perhaps skim the cream, take the easy rich kids and leave the tough cases to the public schools. But if there were no private schools and those children had to be educated in public schools, the entire system would collapse.

Many facts and figures are thrown around about hospital growth. It's really not as great as people think. In terms of hospitals and beds, we're growing at about a seven percent rate—an industry that used to be totally physician-owned, by the way, until 20 years ago. All the investor-owned hospitals were once relatively small doctor-owned hospitals, which are now declining at the rate of about six percent per year. Some are simply closing down, as is the case in New York State. Others are being sold to profit-making companies. There are now about 1,200 investor-owned hospitals. About 75 percent of them are owned by 64 companies, which own three or more hospitals. They have now reached into all 50 states, not just the sunbelt states of Florida, Texas and California. We have 65 hospitals in 25 countries overseas that are investor-owned and another 14 that are investor-managed. And we have another 300 in the United States, with 45,000 beds, which are investor-managed.

A trend worth noting is that the private sector is doing many of the same things that we are doing in an attempt to save money, become more efficient, and increase productivity. I think that it's good for America, it's good for consumers and it's healthy competition. The VHA and the American Healthcare Systems are doing many of the things we are doing and they are much more alike than they are different. I really think we're both part of the medical industrial complex, proud of it and that it's a good thing.

There were three million workers in the nation's six thousand hospitals and one hundred thousand of those jobs have disappeared in twelve months.

All of these policies have resulted in a lot of numbers. A hundred thousand people who worked in the hospital industry one year ago no longer work there. There were three million workers in the nation's six thousand hospitals and one hundred thousand of those jobs have disappeared in twelve months. That is a result of the crunch that we are here to talk about. It's the result of DRG's and economic pressures from the private sector. I think a lot of that may have represented featherbedding in a cost-reimbursement environment, but if it keeps going at this pace, it's going to reach the point where some will question quality. You can't keep reducing the work force.

In terms of integration, I think that phase two of the revolution that you have been hearing about all morning is going to be the merger of delivery and finance. What that simply means is that the successful company in the health field in the future is going to have to become more like an insurance company. It's going to have to both underwrite as well as deliver the care. It's going to have to deliver it out of as well as in the hospital. That may seem like an HMO, but I think it could look very different. There will be all sorts of hybrid organizations. There will also be a lot of joint venturing between for-profits and non-profits. Two psychiatric teaching hospitals are being built this year under joint ventures where the non-profit teaching hospital and for-profit company are 50/50 partners in developing a teaching facility. The non-profit partner put up land as its share of the partnership, the for-profit company put up capital. I think you're going to see more of that, in addition to these HMO hybrids and options.

As for the HMO option under Medicare, Carolyne Davis said that the department predicted 600,000 out of a total of 27 million Medicare beneficiaries might sign up in one year. And she thought that that estimate was low. Our estimates are for about two million new subscribers, perhaps much more than that over the next five years.

An example of one of the new hybrids is Humana Care Plus, which I think is one of the most exciting developments in the health field. It's only been marketed for 14 months and 200,000 people are now subscribers to Humana Care Plus. It is, in effect, not an HMO and not a PPO but technically an insured PPO. There is total freedom of choice in physician, but it's a preferred provider arrangement on the hospital side, starting off with Humana Hospitals (though in some cities non-profit hospitals are also contracted) and it is pre-payment, like an HMO. So an employer, in effect, is guaranteed a per employee total health-care cost for a set number of years, which will not increase beyond a specified level—usually the CPI. David Jones has gone into direct competition with Blue Cross and Aetna. The reason I think the HMO/CMP option is the wave of the future, and so much more of a landmark that DRG's ever will be, is that about half of the Fortune 500 companies now self-insure.

That means that they abandoned traditional insurances because they were not

Physicians can do a lot of things to affect change. I think the DRG system clearly was intended to change physician behavior by penalizing the hospital for it.

satisfied. Whenever large purchasers are dissatisfied, some innovative, bold leader will come forth with a plan to try and satisfy them, and some of those innovators will succeed. I think Hospital Corporation of America is doing something very similar with its Primed Plan. They are horizontally as well as vertically expanding with the American Supply merger. They can, and want to, do both.

National Medical Enterprises has set up something called Preferred Medical Systems, which is really nothing more than technical assistance to hospitals and their medical staffs on how to set up PPO.

And the latest entry into the field is AMI, with its AMI Care. It is very similar to Humana Care Plus, a company that has tripled its non-inpatient revenues in the last 12 months, mostly through about 30 surgery centers.

The target of cost containment, and the crunch that is bringing about all this change, obviously starts with the hospital. I'm struck by the fact that if Jimmy Carter were President today and were proposing half of the things that Ronald Reagan is proposing, there would be an outcry in this country beyond anything you've ever heard. Freezing hospital fees for a year, freezing physician fees for another year. I'm amazed at how slow we are to start opposing Reagan, but I think it's coming. The hospital industry has suffered $10 billion in cuts over the last four years and the President is now proposing another ten. Medicare has been cut over $20 billion over the last four years, and he's proposing another twenty—notwithstanding the fact that Medicare hasn't contributed one cent to the federal deficit because it's still running at a surplus and it's a trust fund. So we're in for some fights ahead and so are the physicians. It's clear the government has physicians next in their sights. I don't think you're going to see DRG's for doctors, ever. I think you're going to see some kind of relative value fee schedule, but it, too, will be renegotiated down.

It is very clear that mandatory second opinion is on the list of things Congress might do as early as this year. It is true that income level is an important issue to physicians, but I also think the question of power and authority is also very important and I think that is what scares some physicians. I tend to see them as the old guard. The call for mandatory second opinion is coming from private employers, consumers and others who want change. There is still room for the physician to be in charge. He will always be the key player. But the message is that those who just sit around and worry about change are going to be left on the sidelines.

Physicians can do a lot of things to affect change. I think the DRG system clearly was intended to change physician behavior by penalizing the hospital for it. Physician relationships with hospitals are becoming very blurred, with doctors taking patients who would previously have been operated on in the hospital, and performing surgery out of the hospital in other groups instead. Hospitals are doing the same thing in reverse. But we believe that the future holds even more competition between physician and hospital groups. Physicians have a lot to gain from for-profit or non-profit companies in the health field: finance, marketing, systems management, insurance, capital equipment, teaching and research affiliation, and private fundings. Last year Humana donated $1.4 million to Louisville for a cardiovascular research institute. Last year Dr. DeVries came to Louisville, strictly because everyone else ran out of money.

HCA has set up a foundation with two percent of its stock—hopefully to reach $100 million—set aside for university research.

And hospitals like George Washington University Hospital, which are making a profit or surplus, still want to sell because of the incredible capital renovation that is needed. Forty percent of the hospital beds in America are 30 years old. Who's going to pay to refurbish them? Not the taxpayers.

I want to say a few things about profits. I think it's worth noting that the profit margin in this industry is five percent, and all hospitals need that margin to maintain services and to remain competitive.

Finally, to the physicians who are really concerned about the growth of the for-profit sector and the non-profit corporations, I would say that when you pick up the newspaper and you see a headline that says "Major Teaching Center Sold to For-Profit Chain", you may feel scared. But I would hope that you would all be much more scared and troubled if that same newspaper had a headline which said "No More Government Money for Medical Research, Teaching, Education and Quality Care." If the money doesn't come from the private sector, it won't come from anywhere else, and we will just have to freeze the health system that we have.

Concerning indigent care, "Sixty Min-

The one good aspect of the health system and the way it's headed is that we're getting away from having the government make all the decisions for us.

utes" did an excellent program based on Parkland Hospital in Dallas regarding patient dumping. I only had one problem with the program. It omitted to mention that two out of the three hospitals which were dumping were non-profit, tax-exempt hospitals. It's typical. I don't want to get into the debate of saying that four percent of our work is charity, which is exactly the same percentage as the nonteaching, nonpublic, non-profit hospital. That's what the facts are. But it's easy for the media, and it's going to become even easier for our competitors, to use emotionalism to rile people up about for-profits. They should, instead, be venting their anger at government. Because the southern states which passed $2,600 to $3,000 Medicaid eligibility levels in their statutes are the ones that should be embarrassed. They're the villains, and all hospitals should band together to attack them. Instead, in a competitive marketplace where people are worried about surviving, the short-term emotional reaction is to go after the hospital that's doing well and say "Let's use the Robin Hood method and tax them and let government off the hook." That is exactly the wrong thing to do.

In conclusion, I simply want to say that the one good aspect of the health system and the way it's headed is that we're getting away from having the government make all the decisions for us. The winners and losers aren't going to be determined anymore in Washington. Instead, they will be determined by people, private employers, labor unions, consumers and patients—all of whom are going to decide who they want to go to for their care, what kind of care they want and perhaps, to some extent, how much they want to pay for it. The government's concern should be to provide for the indigent. The government provides public housing for the indigent, and gives them food stamps. So why not have the government provide them with health care too, instead of letting the hospitals do it themselves?

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CHARLES EWELL

Managing the Not-for-Profit Hospital

American Healthcare Systems is a relatively new organization. Why was it created? What good is it? And how does it differentiate between the way the non-profit and the for-profit chains work, because there are many similarities?

American Healthcare Systems was formed as a result of a merger between two non-profit hospital groups in 1984. It then contained 28 multi-health systems, now has 30, and we anticipate having 35 before the end of 1985. It encompasses about 275 non-profit hospitals, and about 650 hospitals affiliated through certain joint-purchasing arrangements, capital development arrangements, marketing programs and so forth. The total revenue is about $7 billion. The hospitals owned, leased or managed by the 31 shareholders are located in over 40 states.

If AHS were on the Fortune 500 list of industrial corporations, it would rank about 50th. It would be about equal in size to Coca-Cola or Johnson and Johnson, about twice the size of Campbell's Soup or Owens Illinois, three times U.S. Gypsum or Gillette, four times Corning Glass or Zenith Electronics, five times McGraw-Hill or Polaroid. That gives you some idea of the economic clout when you do things together.

It's the largest multi-health system network in the United States. The shareholders are primarily non-profit systems. These are not hospitals with capital access problems or marginal profits. These are healthy, vibrant hospitals. They are Methodist, Catholic, Lutheran, Mormon, Presbyterian and many with no religious affiliation.

It's the rare hospital today that goes it alone. Many analysts say that, by 1995, all health-care services in the U.S. will be provided by 15 to 20 large health-care organizations, some for profit, some non-profit.

Why was American Healthcare Systems formed? Why did all these hospitals decide to do something together? Several driving forces were primary: maintaining the quality of our services, improving the financial position of our hospitals, improving the market position of our hospitals and maintaining local control. It's very important to these hospitals that they maintain the local control of their individual boards.

In addition, American Healthcare Systems was formed because of the competitive environment; with DRG's, HMO's, and the fact that two out of every three of the over 6,000 hospitals now in the U.S. are affiliated with some kind of multi-hospital organization.

It's the rare hospital today that goes it alone. Many analysts say that, by 1995, all health-care services in the U.S. will be provided by 15 to 20 large health-care organizations, some for profit, some non-profit. But having predicted the weather, remember the Noah Principle, which says that predicting rain doesn't count; building arks does.

American Healthcare Systems is in the ark-building business. The advantages of moving together include the economies of scale; the new capital strategies in both the debt and equity side that are unfolding very rapidly in our favor; the national marketing and insurance networks such as HMO's and PPO's which allow us to go to national and regional employers and offer insurance contracts and products; the need for diversification in new home health-care products on a national basis; and the belief among our group that the non-profit community hospital system was worth keeping. Over 85 percent of the beds in America are still in non-profit hospitals. We largely do control the hospital industry, nationwide.

The final advantage of American Healthcare Systems is that it is a positive alternative for the non-profit hospitals, so that they won't have to hand over the keys to someone else, as a half dozen large hospitals have done in the last year or so by selling out to for-profit chains.

What benefits do shareholders get through American Healthcare Systems? They get savings through the joint purchasing contracts; new revenue through new business ventures, market protection through the national network; new capital through new investments; and finally, and perhaps most importantly, an alternative to selling out.

Some specific examples illustrate these points. One is in the capital area. We have just announced (in the trade journals, in

I thoroughly agree that the HMO, the PPO, the hybrid kind of organization that puts doctors and hospitals at risk through agreements under contracting arrangements, is the wave of the future.

the current issue of *Modern Healthcare*) the creation of a new venture capital fund. This fund will establish a $45 million pool to be used for investment in new high-tech health-care technology companies. We will examine candidates who wish to have capitalization from our hospitals. And that fund, which will be managed separately by Wall Street experts, will take an equity position in, and will grow with, those companies. That fund will give us two things. First, it will give us a "window on technology." We will learn early on about the new developments, and which ones could sustain market advantages for our hospitals. Second, it will give us a return on investment that is quite good. Last year, among the 250 venture capital firms in the U.S., the average return on investment was about 27 percent. I don't have to tell you how much capital can be generated from a new high-tech health-care company that realizes market success and takes its stock public.

Another example of the strength of acting together is our enormous purchasing program, which enables us to buy items in large quantities. In total, our hospitals buy about two billion dollars a year of medical supplies and pharmaceutical and capital equipment. We save an enormous amount of money.

The for-profit hospitals have done this for years and have proven the point. For example, we recently learned that 20 of our systems were shopping for MRI's. Magnetic Resonance Imaging, as you're aware, costs about two million dollars per copy. So we arranged for those 20 hospitals to meet with five MRI vendors. By contracting as a group, our savings were about eight million dollars on that one item alone! And as I said, we purchase about two billion a year in contracts. So our savings opportunities are in the hundreds of millions of dollars.

Another opportunity is vertical integration, the acquisition of other kinds of businesses. This must be done carefully. We are shortly announcing joint ventures with America's largest home health-care company in order to form a partnership with them. But vertical integration carries its own potential problems. You can make mistakes. I, for one, think the recently announced merger between Hospital Corporation of America and American Hospital Supply is not going very well, at least in terms of Wall Street's reaction to it. A stockbroker told me that American Hospital Supply has 72,600,000 shares outstanding and their stock price dropped from 37 to 30½. Hospital Corporation of America has 87,581,000 shares outstanding and their price dropped from 46⅛ to 41¾ within three days after the merger was announced. These numbers mean that the owners of those two companies realized a combined paper loss of approximately $900 million of value. So vertical integration cuts both ways, and we want to move carefully and make sure that we do it well.

I thoroughly agree that the HMO, the PPO, the hybrid kind of organization that puts doctors and hospitals at risk through agreements under contracting arrangements, is the wave of the future. We will be nationally marketing insurance products with the national employers and through regional contracts.

Finally, let me describe some differences between the profit hospitals and the non-profits, because I do believe some differences exist and they can be confusing. Of course, there are many similarities between the two segments. Both are under enormous cost pressure now from the DRG environment and from business and industry. Both must make a profit at year end. Both have top-flight senior executive teams. Both have dramatically cut costs in the last year and a half, primarily through lower utilization rates based on shorter lengths of stay in a hospital. Both operate in a businesslike manner. As a Catholic nun told me recently, while arguing the balance between ethics and economics, "You have to do well to do good." We recognize that. We both have approximately the same costs of care and operating efficiencies, based on studies done by third parties.

There are some differences. First, there are many more of us. As I said, about 85 percent of the U.S. beds are in the non-profit hospital sector. And I don't see that changing drastically. Interestingly, at the turn of the century, most hospitals and nearly all medical schools were for-profit. Second, non-profit hospitals are much larger facilities. In California, for example, which has the largest percentage, the for-profit hospitals average 103 beds and non-profit hospitals average well over 225 beds. Third, most teaching and research are done in non-profit hospitals. As I said, all of you in this audience were trained in non-profit hospitals. I must say that we are delighted that the for-profits are interested in sharing the responsibility for teaching and research costs. It was not a very profitable area in the past, I might hasten to add, and I'd like

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to have some long conversations about why that segment of the market is attractive to the for-profits. But we certainly look forward to greater sharing in that area and we encourage more sharing of teaching and research costs by them.

I'd also like to comment on that University of Louisville case reported in an article in the current issue of *Review*, the trade journal of the for-profit organizations. The Louisville case suggested that Humana Hospital earned a one percent pretax profit last year. My only question would be, how long can an organization that is used to having substantially higher pretax profits overall afford to stay in the business of teaching and research? One percent profit is just not going to cut the mustard on Wall Street. I also might have asked Mr. Jones earlier in this program whether any of the administrative costs for those big computers which were shifted from the hospital to the corporate national office in Louisville have yet been applied to the total costs of running University Hospital there?

What the American public wants is continuous reliable quality health care for all of its people at a cost that is reasonable and defensible.

Fourth, the profits in our not-for-profit hospitals, which sounds like a contradiction, are not sent to stockholders out-of-town. They're kept "in town" and used for equipment, facilities, salaries and so forth.

Fifth, according to a recent Johns Hopkins study, the price of care in the non-profit chains such as ours is 21 percent lower than the prices in the for-profit chains.

Sixth, non-profit hospitals don't pay taxes. We have opportunities for community fundraising and we can raise money for capital purposes through tax-free bonds, all of which are not available to the for-profits and are a significant advantage for us. I think we have a great many advantages over the for-profit hospitals.

Seventh, the inpatient census is much higher in non-profit hospitals. It's about 65 percent in the non-profits, compared to about 55 percent in the for-profits. In fact, several of the large for-profit chains are operating now at under 50 percent occupancy.

Eighth, the large majority of for-profit hospitals are still in the sunbelt states, concentrated in Florida, Texas, California, Tennessee and Kentucky. And I think that's likely to be the case for some time in the future, and limits their ability to market on a national basis.

Let me wrap up by quoting a comment by my colleague, Dr. Merlin DuVal. Many of you know Dr. DuVal, former Dean of the University of Arizona Medical School and Assistant Secretary at HEW, who is now representing our organization in Washington. He wrote, in a recent letter to the *Los Angeles Times*, "What the American public wants is continuous reliable quality health care for all of its people at a cost that is reasonable and defensible." It's our feeling that the non-profit system, through creative and competitive new forms such as American Healthcare Systems, will meet that objective as we move toward the year 2000. And may I remind you that the year 2000 is only as far ahead of us as 1970 is behind us.

JEANE KIRKPATRICK

KEYNOTE SPEAKER

I used to have students at Georgetown in those years, clear eyed and fuzzy minded, who all believed that the public good would be deeply served if only we could quickly socialize medicine and the pharmaceutical companies. Most of those students grew older and more sensible and gave up those arguments.

This is my very first meeting with a pharmaceutical company. Although I've taken a little medicine in my life, I've never really thought about pharmaceutical companies at all, not until the early 1970's, when the radical consumer movement of those years suddenly brought the pharmaceutical companies to our attention. I guess you remember that campaign, which suggested that most deaths were caused by medication, and that they were usually the fault of the pharmaceutical company. That campaign left the impression that if there weren't pharmaceutical companies and medicines, nobody would die at all. As a matter of fact, in those days we heard a great deal about careless tests and misleading advertising and fat profits. After listening a while to what they said and looking at the people who said it, I decided pharmaceutical companies really couldn't be all bad.

I used to have students at Georgetown in those years, clear eyed and fuzzy minded, who all believed that the public good would be deeply served if only we could quickly socialize medicine and the pharmaceutical companies. Most of those students grew older and more sensible and gave up those arguments. But I moved on to a place where such arguments were very commonplace.

As a matter of fact, the very first issue that we confronted in the United Nations, after I went there at President Reagan's request in January 1981, was not so far removed from pharmaceutical companies.

It was called the Infant Formula Case or the "Nestle Question." How would we, the United States, vote on a code proposing to govern the marketing of infant formula and other products in the world, particularly in Third World countries. The code had been developed inside the World Health Organization. You may recall that over the previous period of four or five years, there had been time for it to be discussed and drafted and commented upon by governments and by consumer groups. The previous administration had entered some objections to the code and those objections had been taken into account (or at least people said that they had been taken into account). Major industry groups had even said that the code wasn't as bad as they had feared it was going to be and seemed at least half-reconciled to its adoption. In its final form, it was less punitive than it had been when it started out. Some industry representatives, however, and some conservative consumer groups insisted that it was still very bad, that it was profoundly hostile to private companies and the multinational corporations. Debate raged, believe me. People brought memoranda to our houses and to our offices late at night, and early in the morning; infant formula really became the centerpiece of our policy concern in the United Nations for that first early period.

The proponents of the code all made it sound as though infant formula were poisoning Third World children and seducing Third World mothers, with misleading advertising, into abandoning breast feeding. I don't know whether you've seen that propaganda, but it really sounds as though it were the multinationals versus the babies.

Opponents of the code noted that it contained prohibitions on advertising, which clearly constituted unconstitutional restraints on free speech. Opponents also emphasized that restrictions were broad and would apply to a great many products besides infant formula. And they also warned that if this code were approved, it was clearly going to be only the first of a number of such international codes drafted by WHO, approved by the United Nations members, and administered by some United Nations agency.

We knew, for example, that the pharmaceutical code, which had been in the works for years, was already nearly complete and was scheduled to be the second of the codes to be adopted.

The Director General of WHO, whom perhaps some of you know, a charming and broadly educated man, visited Washington and tried hard to persuade us all

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that the code was, at worst, harmless. He said that it was, in any case, too late to stop it and that if we were to try to, we would be dashing the hopes of mankind.

Those were the days that Richard Schweiker was the Secretary of HHS. Dick organized a lunch for the Director General at which, I remember vividly, the Director General proposed a toast. Toasting, by the way, is a big activity in the United Nations. The toast went as follows: "The noble art of losing face may someday save the human race." He then proposed that we should try hard to develop that noble art and, inferentially, thereby save the human race.

He was not quite sure that we, in the new administration, understood what our duties were in the world. We weren't supposed to protect ourselves, much less try to protect the institutions of our society.

In fact, the code was quite a serious matter. It had, we thought, the possibility of closing important markets to entrepreneurs, privately-owned enterprises and multinational corporations. It certainly would have the effect of further concentrating control over both the economy and the right to free expression in Third World countries. Most of these governments, of course, are already top heavy. Clearly, the codes would deny choices to consumers. They did such things as forbid the sale of foreign foods in Third World countries, on grounds that it constituted a kind of cultural aggression. We wondered if only the rich and powerful were to be permitted the pleasures of, let's say, Chinese or French food. Apparently so.

The code also would have powerfully stimulated the growth and the powers and the size of the international bureaucracy, many of whose members are themselves profoundly committed to a kind of global socialism.

The United States was faced with some interesting choices. We could, of course, vote yes. If we had done so, we would have been voting with all the Third World countries, all Soviet bloc countries and most industrialized democracies. That's what civilized nations were expected to do and it was strongly thrust upon us that it was our duty.

We could, on the other hand, abstain—which, it was suggested would not be unbearable, although clearly unfortunate.

And finally, we could have voted no. It was clear the resolution was going to pass overwhelmingly, since most of the member nations were going to vote for it. And there's no veto in an organization like WHO. However, it was understood that our negative vote would signal the attitude of the new administration. And since the United States is the principle financial supporter of WHO, it would be regarded as profoundly discouraging if there were a negative vote. Any vote by the United States was expected to have a major impact on subsequent policies of WHO.

Well, as I'm sure you all know, after quite careful and thorough consideration, the President bit the bullet. We voted no, and it was not the last time the United States stood alone in the United Nations.

The repercussions of that decision and that vote are still being felt, four years later, in our government, in the industry and in the United Nations. When we voted no on that infant formula code, we announced that the United States would no longer leave American companies to the distinctly untender mercies of hostile international regulations. That was a new departure and, I am told, a good many United Nations bureaucracies and bureaucrats changed almost immediately following that no vote.

By that no vote, the United States also announced that the Reagan Administration was not unwilling to stand alone, if necessary, against policies which we thought were hostile to our institutions, our values and our Constitution.

We explicitly adopted the principle that the United States would oppose any policy, inside all United Nations agencies, which would be unconstitutional under the American Constitution. That, too, constituted a real departure from previous policies.

In voting no, our government also made clear that the new administration decidely did not share the ideology that had dominated international agencies for years and had seeped into a good many departments of our own government and infected a good many of our own bureaucrats. According to that ideology, state-owned enterprises and heavily regulated state-managed enterprises are essentially morally superior to privately-owned ones. That sounds like an exaggeration, but it's not. Another tenet of that ideology is that rich capitalist countries and their enterprises exploit Third World countries whenever they have the opportunity, plundering their markets and their resources, exploiting their people. Yet a third tenet of that ideology is that it is the business of the United Nations to protect poor Third World nations from rich capitalist countries and

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that a bureaucracy capable of doing that should be brought into being and, of course, paid for by the rich capitalist countries who are the objects of its untender ministrations.

The facts, of course, are entirely otherwise. The worst thing about that ideology, and the reason we confronted it head on for the four-plus years that I was representing the United States in the United Nations was, of course, that it was wrong as to the facts on every score. It was also hostile to our own country's interests and the well-being of the very Third World countries which it purported to assist.

State ownership and management is, in fact, not necessarily conducive to superior health care.

It was perfectly clear that the United States, in voting no on the infant formula code, began its campaign to set the record straight on economic development and health care in the world body and, indeed, in the world. Nothing is clearer than that.

State ownership and management is, in fact, not necessarily conducive to superior health care. There is no clearer evidence of this than, for example, the Soviet Union. Just last week, the *London Times*, noted that the incidence of measles—according to published Soviet statistics—is now so high that it stands only fractionally below the level at which epidemiologists attribute measles to malnutrition. Infant mortality, they said, is rising, and life expectancy is falling. A recent issue of published Soviet medical literature says that some five out of seven key communicable diseases are out of control: polio, diphtheria, scarlet fever, whooping cough and measles. Some Soviet health problems are, of course, directly related to that society's incredibly low quality of life. It is, for example, shocking to learn that in non-Moslem urban areas, abortion has become the principle form of birth control, with not a few Soviet women undergoing approximately six abortions in their lifetime, often without medical care.

Alcoholism is rampant. Deaths from acute alcohol poisoning stand at 16 per 100,000, a figure unheard of in other countries. It is more that 88 times the level of deaths by alcohol poisoning in the United States.

The decline in Soviet standards of living and economic performance is so dramatic and so pervasive that no one who really looked at it would think that their system of economic centralization and state control would be a model for economic development.

Of course, a vast array of data from other countries all suggest that freedom works, that people work harder when they're free to pursue their own individual goals and to benefit personally from the fruits of their labor. The evidence of this fact, that freedom works and that individual motivation works, is seen in the really stunning discrepancies between the agricultural production on private plots and on collective farms. In the Soviet Union itself, in Poland, in Hungary, in the People's Republic of China, they began to notice that farmers produced so much more when they were permitted to till their own plots and benefit from their own labor, that they revised their own system. They thought that they had made a major discovery about human beings and human behavior. They gave a name to their discovery. They called it "the responsibility system."

Nobody thought it polite to mention that Adam Smith described it in considerable detail some centuries before. The contrast between social and economic systems based on centralized state control, and those based on personal freedom and individual motivation, is nowhere more clearly observable than in such countries as South and North Korea.

In the last decade, the average annual economic growth rate in South Korea has been something over seven percent. The average economic growth rate in North Korea has been one percent. The people are the same, the cultures are the same, only the economic and political systems differ.

Compare, for example, East and West Germany, or Austria and Czechoslovakia, or Malaysia and Vietnam. The story is the same, no significant difference in the people, no significant difference in their history, culture or tradition. Only the economic and political systems differ. Where one looks at actual economies or actual social systems, one sees again and again that the views expressed by Adam Smith, about freedom and about the wealth of nations, are confirmed. And the views of Karl Marx quite simply don't stand the test.

The proof of the pudding, after all, is in the eating. And that Marxist pudding is indigestible, even in the United States. In the last four years our experience has reminded us of the real sources of wealth. Last year's real growth in GNP, for example, was the sharpest increase since 1951 and inflation was the lowest since 1967. The overall result of the economic policies of the United States in the last four and a half years has been the creation of over seven

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million new jobs in just two years. We are now creating some 300,000 new jobs each month. That is rather remarkable.

The United States revised its tax system to provide more real incentives to work, to save, to invest, to take risks, to be efficient. We reduced government regulation, intervention and control. We opened opportunities for freer competition in transportation, finance, communication, manufacturing and distribution. This policy was so successful that it has attracted a great deal of foreign capital to the United States and produced the strong dollar about which we hear so much.

Nothing succeeds like success, of course, and success inspires emulation. In East Asia and indeed in every other country in Europe, Latin America, Africa and elsewhere in Asia, we see movement today to decentralize, to deregulate, to denationalize, to reduce rigidity and to increase the ability of individual producers and consumers to cooperate freely.

And around the world, particularly where there are free economies, we also see a worldwide revolution in economic thought and economic policy. Some people call what is underway the "third industrial revolution." Walter Wriston called it the "onrushing age of information technology" and everybody who studies it agrees that it is fantastic and that we are already in the midst of it. It's that combination of microchip computers, advanced telecommunications and continuing innovation that is transforming every aspect of human endeavor today. As we all understand, the implications of this new industrial revolution are not only economic. The very existence of these technologies is proof of the critical contribution which freedom and entrepreneurship make to development. Government policies that give free reign to entrepreneurship turn out to be the well-spring of technological creativity, as I'm sure they are in pharmacology and medicine as well. Closed societies fall far behind in these developments. Closed societies fall even further behind in the new industrial revolution and the new informational revolution than they are in the older techniques. It's impossible for governments to simultaneously control information flow in a centralized fashion and reap the benefits of the information revolution.

Government policies that give free reign to entrepreneurship turn out to be the well-spring of technological creativity, as I'm sure they are in pharmacology and medicine as well.

The free flow of information is, of course, inherently incompatible with a highly centralized, controlled state system. And it is inherently compatible with our political system and our values. That is, of course, the reason that we have made such fantastic strides forward in that area.

I know that many people worry about us being behind the Japanese. I recently heard a story that illustrates this concern. A United Nations trade delegation, consisting of one Frenchman, one Japanese and one American, went to an African country, probably Upper Volta, to see if they could help economic development there. While they were in that African country there was a violent coup and they were arrested and thrown into a crude prison. They were dragged from their cells that night and sentenced to be executed the next day. Naturally they were pretty upset. The ambassadors and the governments intervened, but the new revolutionary junta refused to release the delegation. "We have to make clear to the world that we are serious about ending exploitation," said the junta. "However, we are civilized people and we will permit each of these prisoners to have one last wish before we shoot him tomorrow." And so the next morning they lined up the prisoners and they turned first to the Frenchman and said, "What is your last wish?" The Frenchman said that before he died he would like to hear the French National Anthem once more and sing all its verses. And when they turned to the Japanese, he said, "Well I would like to make a short speech on Japanese management techniques before I die." And then it was the American's turn. He said, "Just shoot me. I don't want to hear that speech."

We all feel that way sometimes, but the fact is our economy is fantastically successful and we've been in a fantastically successful period of innovation and growth in both our technology and our economy.

In fact, we've been so successful, we might decide that we have no real worries in the world; that our country and our civilization and our world are safe and that we will all live happily ever after. But, of course, only stories end that way—Hans Christian Anderson and Karl Marx. In the real world, we are usually confronted with more problems, and the truth is that today there is a lot to worry about.

While the Soviet Union is no good at all at delivering health care or economic growth or a high standard of living—it hasn't even met its housing standards for 1928 yet—it is, as the *London Times* wrote, "a Third World economy with First World weapons." During the Brezhnev era, there was phenomenal and persistent growth in

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Soviet military spending and military development.

In 1983, the CIA calculated that Soviet defense spending was 25% higher than U.S. defense spending. It's really hard to imagine such defense costs in an economy as weak and crippled as that of the Soviet Union. But it's the truth.

The strain of maintaining such defense expenditures is, of course, great in such an economy. But the Soviets have borne that strain for a long time, long enough to have achieved what they call a change in the "world correlation of forces." They talk a lot about that changed correlation of forces. They believe that by the changed correlation of forces in the world, they have demonstrated their superiority, which they believe is historically decreed. By that changed correlation of forces, of course, they mean that the West lost military and strategic superiority, and that they gained it.

General Ogarkov, for example, talks frequently about how the changed correlation of forces in the world is irreversible and "exposes the historical futility of the capitalist system."

It's interesting to recall that in 1960, Nikita Khrushchev, who you remember was convinced that they would bury us, made two predictions about the next 20 years. He predicted that by 1980, the Soviet Union would have overtaken the United States in economic production. That prophecy was obviously pitifully wrong. But he also predicted that by 1980 the Soviet Union would have triumphed over the United States, not through nuclear war, but by the expansion of its influence in the Third World. The fact is that the change in the so called world correlation of forces in the years before 1981 consisted of two elements: first, the growth of Soviet military power along with the concomitant decline in the military power of the West, and second, the dramatic expansion of influence in the Third World. Now, in fact, we know more about how to handle the development of Soviet military power than we do about how to handle their expansion in the Third World. Because we can, in fact, increase our own military development, expenditures and production. And we have done that. And we can, of course, attempt to deal with the arms race through arms control negotiations. But we don't even have an adequate theory for dealing with Third World expanded influence.

It is difficult to remember, even today, that in just 20 years, from 1960 to 1980, the Soviet Union progressed from a purely continental European power to becoming a global power, acquiring bases and surrogates in Cuba, Vietnam, Ethiopia, Angola, South Yemen, Mozambique, Nicaragua and Afghanistan, and expanding its military reach to the vicinity of such strategic checkpoints as the Panama Canal, the Straits of Gibraltar, the Suez Canal, the Straits of Hormuz, the Red Sea, the entrance to the Red Sea in the Indian Ocean, Cambodia and the sea lanes of East Asia.

In the same 20 years, the number of Soviet and Soviet-bloc troops in the non-Soviet, non-Warsaw Pact countries increased more than 500 percent to more than 125,000 troops in Afghanistan, 125,000 Vietnamese troops in Cambodia, more than 50,000 Cuban troops in Africa, 10 to 12 Cuban and other Soviet-bloc advisors in Nicaragua, and so forth.

They are doing very well in the world, strategically and militarily. The fact is they know a good deal more about how to succeed in that area than we do. We, of course, do not desire to expand our influence and control other nations. We do seek to maintain a world of independent nations, in which to trade and travel and educate ourselves and with whom to thrive and to enjoy life. But we have not done very well at maintaining that world of independent nations and discouraging Soviet expansion and hegemony.

A top Soviet official told the former French President, Giscard d'Estaing, "We took Angola and you did not protest. We even saw that you could have beaten us in Angola. The government was on our side, but it was within an ace of giving up and yet you did nothing to win. On the contrary. When, to save ourselves, we sent in 30,000 Cuban soldiers, Ambassador Young, a member of the American Cabinet, said it was a positive step and an element of stability. All right, we noted the fact and included it in our analysis. Then we took Mozambique. You didn't even know where it was on the map. Then we took Ethiopia, a key move. There again we noted that you could have replied via Somalia or Eritrea or both. No reply. We noted that and put it into our analysis. Then we took Yemen and set up a powerful Soviet base *there*—Yemen, on the Arab peninsula, in the heart of your supply center. No response. So we noted that we could take Yemen."

They noted they could take Yemen and they could continue to expand. Grenada

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came next, then Nicaragua. The truth is that they are very good at expanding their power. We are very good at producing goods, but we are not very good at expanding our own power. We don't desire to, but we're not very good at maintaining the kind of world we want to maintain, or the preconditions for that kind of world. It's not entirely clear what we should do about that. It's quite clear that we should not be lured into fighting on a hundred fronts. That peace-loving leader of Libya, Omar Khaddafy, in a speech a few months ago, said that he was going to force the United States to fight wars on a hundred fronts. He's bragged since then, by the way, that he has sent Libyan troops to Nicaragua. I don't know whether that's true. I rather doubt it. There are Libyans in Nicaragua, but I don't think they're fighting there.

Obviously, we cannot allow ourselves to be lured into one hundred wars on one hundred fronts, or indeed any war in any place, endangering our own ability to survive and remain strong and gain and thrive and enjoy our lives. What can we do? I think we can learn from the Soviets. Only in the case of Afghanistan have they sought to achieve their political goals by using their own troops, and today even they may think that was a mistake.

In the United Nations, at the end of the last General Assembly in December, my Soviet colleague, the Permanent Representative, commented to me rather gallantly that we, the United States, had been successful in achieving some of our objectives in the United Nations. As he put it, "The United States had a very good General Assembly." I thanked him for the compliment and told him we had learned a good deal about the politics of the United Nations from watching him. We can learn a good deal about the politics of their empire building. From watching them we can see that, generally speaking, they survive and thrive and expand by helping nations on their side to help themselves.

I think we do not ever want to adopt Soviet methods and modes of international behavior, because we have moral scruples which, in fact, would prevent us from doing so. But we can occasionally adopt Soviet tactics when our national interest is deeply at stake, providing those tactics do not violate our moral codes.

I believe the most important of those tactics may simply be to help other people help themselves, where they share our values and seek the same kind of world that we seek.

I'm convinced that international trust, mutual understanding of disarmament, and international security are inconceivable without an open society, which allows freedom of information, freedom of conscience, freedom to publish, the right to travel and the right to choose the country in which one wishes to live.

I'm also convinced that freedom of conscience, together with other civil rights, provide both the basis for scientific progress and a guarantee against its misuse to harm mankind.

I think that Western values of liberty and democracy are today as relevant to our well-being and to the well-being of people all over the world as they ever have been. These values are the source of our strength, economic and moral, and they are a source of strength for every nation that tries them. The centerpiece of our foreign policy should be to encourage more people to try them.

I'm also convinced that freedom of conscience, together with other civil rights, provide both the basis for scientific progress and a guarantee against its misuse to harm mankind.

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JAMES KILPATRICK

A Conservative's View

History is mostly biography, the lengthened shadow of the men and women who made it.

I'm a newspaper man, and have been for almost 45 years. For the past 20 years I've been based in Washington. But it's my good fortune to be able to travel much more than most of my colleagues in the Washington Zoo, to get away from the Potomac and Potomac fever and move around the country. My impression, this spring, is that the country is in an upbeat mood. Former President Carter was fond of speaking about the malaise that he perceived in the country during his administration. I don't see much of anything along those lines.

Most of the economic indices in the country today are really good. The inflation rate in 1985 will stay under four percent, which no other industrial nation in the world can approach. Unemployment is staying flat, at about 7.3 percent. It's too high and there's a real problem there in human terms. About eight million people are out of work, and that's a human tragedy. These are people who are trying to work, trying to find jobs, and the jobs just aren't there. But the other side of the coin is that many new jobs are being created. About 900,000 new jobs were created during the first three months of the year. More than two million new jobs have been created since the summer of 1984. That's an unbelievable record. In March 1985, more than 60 percent of the population was at work. That's the highest figure in the history of those statistics. To me, nothing in those numbers suggests a grave slump, an approaching recession, a depression, or any of those things.

Of course, there are problems. The trade imbalance, which certainly concerns Pfizer and many other manufacturers who have worldwide trade, is very serious. I wouldn't minimize it for a moment. Something has to be done to bring the deficits down, to bring the dollar down, in order to relieve this very serious trade imbalance.

We in the newspaper business had an embarrassing experience recently. The American Society of Newspaper Editors was meeting in Washington. It had commissioned a great thick survey on "confidence in the credibility of the press and other institutions in the country." Respondents were asked to rank ten of this country's professions and institutions in terms of the confidence people had in them. Newspaper reporters ranked eighth out of the ten. We were ahead of used-car salesmen and advertising people. (In other surveys, we've been just ahead of Congress, which is a terrible thing to say about the press.) You'll be gratified to know that medicine was right up at the very top of the list of ten professions in which the people had confidence.

Emerson once observed that history is mostly biography. This has been confirmed by my observations as a newspaperman over the past four decades. History is mostly biography, the lengthened shadow of the men and women who made it.

Mr. Reagan carried the country in November by an astonishing sweep, losing Minnesota by only about 17,000 votes and carrying everything else solidly. It was a great vote of confidence by the people in Ronald Reagan—and I speak not as a conservative, not in any partisan sense. Mr. Reagan has done a great deal to earn that. In a sense, he's like Eisenhower. He projects this fatherly image of steadiness, steadfastness, sincerity and all of these good qualities to which people respond.

The first president I ever met was Franklin D. Roosevelt. I was a young reporter, permitted to stand in on a little press conference in the Oval Office. You either liked Roosevelt's policies, or you loathed them. He was a man with great presence, and the country responded to it. He led the people through the war, out of the Depression.

After Roosevelt's death, Harry Truman—a very different person, but also a very strong one—came on. I first met Truman as a reporter covering Senate hearings. He was a peppery little fella, stood as straight as a rifle barrel, testy, snappy, stiff sometimes, but as he demonstrated with General MacArthur and in the agonizing decision to drop the bomb on Japan, he was

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capable of decisiveness and he, too, was a leader.

After Truman came Eisenhower. To quote Carlyle, "The happiest hours of mankind are recorded on the blank pages of history." The Eisenhower Administration was pretty blank, but it was a good time. Eisenhower was also a leader. If you command nine million men and six thousand ships, it gives you a sense of power.

Then came Kennedy. He was a different type entirely, but also very Presidential. He exuded the sense of command that comes with a fortune of $300 million. That kind of backing makes it pretty easy to get things done.

And then Lyndon. I was just beginning to cover Washington regularly when Lyndon became President. He was the first President I ever really got to know kind of closely. When Johnson grabbed you by one arm, it was known as the "half-Johnson." When he got you by both, it was the "full-Johnson." It was impressive.

Johnson was about six foot two. When he was in a temper, as he so often was, he shot up to about six foot seven or eight. I was writing a regular column and I wrote something about Vietnam that offended him. By mischance, a day later I was at a briefing where the President appeared, and he saw me. Keep in mind that I was just a rookie then. He motioned to me that he had a word or two to say to me in private. We stepped into a little hallway and Johnson, now seeming about six foot nine, was very angry with me. He instructed me in the error of my ways. It was a paralyzing experience for a young reporter and I haven't really recovered from it yet.

Johnson was an amazing man, a leader. He got the foundation of the "Great Society" through the Congress, because he could lead. He had character, personality, vigor and strength.

My favorite Lyndon Johnson story goes back to the time he was at an Air Force base in California for some function. When the ceremony was over, he came down the little flight of steps onto the red carpet, and a deferential young first lieutenant touched him on the arm and said, "Mr. President, your helicopter is over here." And Lyndon looked out and put his arm around the lieutenant's shoulder and said, "Son, they're *all* my helicopters."

Then came the most enigmatic of all the Presidents I've known, Mr. Nixon. He was a star-crossed individual, demon-ridden by a terrible sense of insecurity. From his perspective, there never was enough campaign money, never enough backup, never enough certainty. And there were those dreadful last two years of his administration. I was rereading some of the Nixon-era material just a few days ago when Sam Ervin died. Ervin, God rest him, was the Senator from North Carolina who led the Watergate investigation in the Senate. I went back to my long shelf of Watergate hearings and reports, and reread parts of Ervin's great book containing transcripts of some of the Nixon tapes. That was 11 years ago. It's hard to see how Nixon could have done the things that he did. But he did, and he paid bitterly for them.

After Nixon came Jerry Ford, the most amiable of the Presidents I've known. He was a man of the House. That was his orbit. I wished that Jerry had stayed there. He was a great figure in the House, but in his two years, he never was able to get much of a handle on the Presidency. An interesting man nevertheless.

Then came Jimmy. We had trouble from the outset with Mr. Carter, because of the "Jimmy." We began to think back in history about "Tommy" Jefferson, "Herby" Hoover, "Woody" Wilson. He was never James Earl Carter. He would never permit that. His recently published papers are those of Jimmy Carter. That was the image that he projected to the country. I remember referring to his campaign as the "love campaign." He would go around and say, "I will never lie to you." And all of us would kind of roll our eyes when he said that, because we had never met a candidate who wouldn't lie to us. Then he won the election, walked down Pennsylvania Avenue hand-in-hand with Rosalyn and little Amy, and walked into the White House, determined to sweep away the last vestiges of imperialism left behind by Jerry Ford (who was the least imperial man that ever walked on two legs, bumping his head as he went).

Mr. Carter was determined to project an image of identification with the people. Out went the color television sets and for a long time there was nothing but those old Philco radios in the White House. No more limousines, just old Chevrolets with raccoon tails flying from the antenna. Hooked rugs instead of red carpets. As many of you know, the White House used to have a great Marine band that played on state occasions. I'm not exaggerating now; this is the truth, cross my heart. For two and a half years Mr. Carter would not permit the

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band to play "Hail to the Chief." They played "Hi to the Chief."

It was the malaise that did him in. Mr. Carter did not have that sense of leadership, of command. He was never able to get along with Congress. It was two years or so before he began to get to know the Speaker of the House. He had problems projecting decisiveness. He had been President for three years and four months when he changed the part in his hair from his right side to his left. This caused a great deal of comment in the press room. The heavy thinkers in Washington asked, "What does this mean? Philosophically, how are we to read this switch?" But we finally decided that any man who got to be 55 years old before he decided where he wanted to part his hair would have real trouble running the country. And so he did.

Now for Mr. Reagan, a different kind of President. Carter has a phenomenal memory for details. He was not much on the broad sweep, but on any little old question, any detail, Carter could snap back the answer. He soaked up the stuff like a sponge. Mr. Reagan, on the other hand, gets the broad picture most of the time. The details he leaves to David Stockman. He's my kind of President. He sleeps in the afternoon. He says, "Don't wake me up when they're shooting down airplanes over Libya. It'll hold until eight o'clock in the morning." And it does. He's not excitable. He's friendly, he's sincere, he gets himself out of these awful scrapes and no one exactly understands how he does it. Right now, the press is giving him hell over his trip to Germany. But he'll come out of it unscathed, the way he came out of the business in Beirut. Pat Schroeder, the Congresswoman from Colorado, called him a "Teflon man." Nothing sticks. It was a great phrase, very perceptive, in Mr. Reagan's case. But I like a President who goes out and rides a horse and doesn't worry too much about these things. As long as people see a serene, confident President, a little sense of serenity and confidence spreads throughout the country. It wasn't like that in Lyndon's day. Sirens were always screaming, limousines were always traveling around Washington in the middle of the night.

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The key outcome of the elections of 1980 was not that Mr. Reagan beat Mr. Carter. At that time Mickey Mouse could have beaten Mr. Carter. The key thing was the Senate changes. With the sole exception of Connecticut, every Senate seat that changed hands in 1980 changed in a more conservative direction. It was phenomenal. There was no way that election could be interpreted except as a sudden revolution against establishment liberalism. One by one, some of the great pillars of the Senate went down: Culver of Iowa, Church of Idaho, Bayh in Indiana. One by one these great liberal Democrats toppled. And across the country, in came the conservatives.

Those of us on the right, the troglodyte wing of the party, said, "Hooray, our hour has come." But it turned out not to be so. The by-elections of 1982 did not continue the conservative sweep. And last November, aside from Mr. Reagan's landslide, there were no very encouraging signs of a revolutionary conservative tide sweeping in. In fact, the Republicans lost two Senate seats.

Looking ahead, in the Congress, we've already gone past the MX missile crisis. The President did win on that one. He had to cash in a lot of chips to do it and he won very narrowly. He'll have a rough time getting the next 21 MX missiles, but the President put his prestige and leadership on the line, and he won.

The White House is not giving up on its effort to provide some token of aid to the anti-Sandinistas. The President hasn't lost that one yet. The country may yet rally behind him on this issue and react to the awful potential of having another Soviet base, similar to Cuba, down in Nicaragua. What this means to Costa Rica, Honduras, to the whole of Central America, is a chilling prospect.

If you read the debates in the House, you find that many of the Democrats who were voting against any sort of aid to the Contras tried to protect their position by denouncing the Sandinistas as well. That battle is not all lost yet.

I'll talk a little bit about the budget. Right now the latest budget compromise (this is the one between the Republicans in the Senate and the White House) calls for fiscal 1986 outlays of around $969 billion, with estimated income of maybe $794 billion, leaving a deficit of $175 billion. That's the best they can do. That's called a compromise—a deficit of $175 billion. How are we going to get these deficits down? The Senate budget committee has come up with a fairly elaborate 20-point proposal for knocking out about 17 different programs and severely reducing others, including

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several of interest to those of you in the medical profession.

Medicaid growth would be capped to save about five billion dollars over the next three years. They're cutting the NIH grants down to about 5,500, instead of the 7,000 that have been sought. That would save $800 million right there. The health profession's training program is to be phased out. The freeze and the reform in Medicare, which would cap payments to both doctors and hospitals, are supposed to save eight billion dollars over the next three years. The most controversial issue, of course, is the proposed cap on Social Security. The proposed cut in cost-of-living adjustments from four percent to just two percent per year over the next three years has stirred up a great storm. The President is being charged with reneging on his promises. President Reagan says he doesn't see how a two percent increase is a reduction. I think it's probably perceived as a reduction in this kind of situation.

The real problem with regard to the budget is to put together a viable package. If, back in the cloakroom, the leadership is unable to reach bipartisan agreement on a package, the whole thing's likely to collapse.

The cuts affect almost everybody. Urban Development Action Grants to the cities would be phased out, and the mayors are screaming. We have gotten addicted to these entitlement programs over the years. General revenue sharing would go too. The rural housing programs would go. The Small Business Administration, which aids only about two percent of all the small businesses in this country, would go. Civilian and military retirement would be cut, too.

Everybody is saying, "Don't cut me, cut somebody else." The Opera Association people were in town a couple of months ago saying that the proposed cuts would spell the end of grand opera in the United States. The cuts affect only three percent of the opera companies' budget, but they claim that if they can't have that three percent, no more opera! And so it goes right down the line. I've seen no one willing to let his budget be cut. Now, if that attitude prevails, we might as well forget about any significant reduction in the budget. Leadership will have to work out a compromise package. They will have to get agreement from Tip O' Neil, from the Democratic leadership, to get that budget through as one complete bundle. Getting that Social Security cost-of-living adjustment in there is not going to be easy. Hawkins in Florida, for example, and D'Amato in New York both have large constituencies. They've announced that they are never going to vote in favor of a package that contains this two percent cap on Social Security. But if they don't, the whole package begins to crumble. So there's a very serious problem up there on the Hill, in pulling things together.

But I'm hopeful, I truly am. I think the mood in the country is good, it's constructive. A lot of people on retirement do not agree with the position of the American Association of Retired People, which is fighting so adamantly against any reduction in Social Security. There are patriotic Americans out there who are willing to sacrifice a little something, as long as the burden is spread evenly across the board. If the leadership on both sides can work out a package in which these reductions appear to be fairly spread, I think it's going to go through. We may even, before the end of the year, get some sort of tax reform. I'm much less optimistic about that than I am about a reasonable budget, because tax reform is going to run into the same problems: "Don't take away my deduction, take away somebody else's." The need for tax reform is great. The President is going to put his prestige behind it later this year and maybe we'll get something accomplished. I would suggest that all of you be of good cheer.

It is the nature of the newspaper business to write about the bad things that happen. The half of the marriages that result in divorce are somehow more interesting than the half that survive. But there is so much good out there in the United States of America that we ought to look beyond the crime, and the drug abuse, and the awful shortcomings in our educational system, and this imbalance of trade, and the many things that legitimately concern us. We should look, rather, at our strengths. Here we are, 230 million of us, speaking a common language (though speaking it very badly sometimes). We have a common currency, a Constitution that's been in existence for almost 200 years. We have freedoms which the people may not perfectly understand but which they know to be a priceless heritage that must be cherished. They're not going to let that heritage be taken away from them. The strengths of this country are great, and the weaknesses, while perceptible and of great concern, are really not that serious.

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VICTOR FUCHS

The Physician as Co-Captain of the Health Care Team

American medicine is now in the midst of a revolution in financing. It's the third revolution since the end of World War II. The first was the spread of private health insurance between 1945 and 1960. The number of people covered for hospital care rose from 32 million to 122 million, and the number of people with insurance for physician's services jumped from 5 to 83 million. That was the first revolution.

The second came, as we say, in one fell swoop. In 1965, Medicare and Medicaid covered many more millions of people, especially among the elderly and the poor. This revolution increased the demand for medical care. It regularized payment, and improved and tended to equalize access. It didn't make access completely equal, but made it more equal than it had been. Medicare and Medicaid were not threats to the practice of medicine. They did not attempt any significant change in the way medicine is organized, the way medicine is delivered, the way physicians practice.

No period since the Great Depression has been more traumatic for practicing physicians. There's a challenge out there, there's a battle for control of medical care.

But the third revolution is very different. You've got Medicare's prospective payment system based on DRG's, state efforts to contain Medicaid, the spread of HMO's, and PPO's, and Lord knows what alphabet they'll invent next week. All of these are very conscious attempts to change the practice of medicine. No period since the Great Depression has been more traumatic for practicing physicians. There's a challenge out there, there's a battle for control of medical care. Now, some of you may know my book, *Who Shall Live?* It was published in 1974 and, when I wrote the chapter on the physician, the subtitle was "The Captain of the Team." If I were writing that book today, it would have a different subtitle. The best that one could say now would be "The Physician - The Co-Captain of the Team," because physicians now have to share power with others. They have to share power with the managers who are coming into the health-care system.

Why is this happening now? And why is it happening with so much intensity? I guess you've heard, often enough, that the driving force is the desire to slow the growth of spending for medical care. It practically begins and stops there. But why this concern *now*? First of all, in the 1970's and 1980's, the economy was growing at a slow rate while health-care spending kept on growing at its normal pace. So suddenly the gap between those two rates of growth became very large. For a period of five or six years, the average gap was over four percent per annum. That is, health-care spending was growing four percent per annum faster than the rest of the economy. That was much above the long-term gap of about 2.7 percent per annum for the last 30 years. And a sense of crisis began to develop within the government and the business community, both of which were paying a large share of the bill. So part of the economic concern was associated with that era in the late 1970's and early 1980's.

Secondly, people increasingly began to say that even the long-term gap of 2.7 percent per annum is not one that we could sustain for another 30 years. If we keep on going with that gap, then health care will just be taking too much of the total economy. There's a very simple piece of arithmetic here. When you're a small part of the economy, you can grow a lot faster than the rest and it really doesn't affect the total economy that much. For example, you're only five percent of the GNP and you're growing at a rate that's two or three percent per annum faster than the rest of the economy. Sure you're taking away a certain amount each year from the rest of the economy, but not much. When you get big, however, when you're over ten percent of the GNP and you keep on growing faster than the rest of the economy, you're taking away much more every time you increase your growth rate. So the larger you are, the greater the stake of the rest of the economy to try to slow your growth.

The third change involves the whole question of third-party payment. Increasingly, there's a realization that when decisions are being made about spending money for health care, they're not being

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Decisions are being made about spending money for health care, they're not being made with a sense that this money is coming out of my pocket and I've got to see whether it's worthwhile.

made with a sense that this money is coming out of *my* pocket and I've got to see whether it's worthwhile. Instead, the feeling is that the insurance company is paying for it, or Medicare is paying for it. So the decision-making is very different. If you go out and buy a car and put down $15,000, you're making a judgment about the benefits of that car relative to the $15,000. You may be wrong but at least you're trying to weigh the benefits and the cost. But if you check into a hospital and get $15,000 worth of tests and you're insured, you're not weighing the benefits of those tests against that $15,000, because the $15,000 is not coming out of your pocket. That's a fundamental difference.

The fourth thing, and this is more of a short-term than a long-term effect, is that we are in a pause—or even a retreat—from the thrust to a more egalitarian society. Some of the changes now represent a retreat from that push toward more equal access. This tension has a long history in America, the tension between a push toward egalitarian ideals and the push toward efficiency and productivity and economic growth.

Now we have all these new systems in place, or coming into place. They have many different features. It's not easy to generalize, but I picked out four characteristics that are true of most of them.

The first is that there are attempts by specific payers to hold down their costs. We don't have any kind of global approach. What we have is Medicare trying to save money for Medicare. What we have is the State of California trying to save money for the state government on its medical program. What we've got is a PPO organized by the XYZ Corp. in order to hold down costs to the XYZ Corporation, and so on. A bunch of individual payers are seeing if they can get the lowest possible price for themselves.

The second feature is a movement toward global reforms of the reimbursement system. Traditional reimbursement is based on a particular service, a particular procedure, a particular day in the hospital for a particular patient. Now, we're moving toward the idea that we'll pay so much for a particular admission, never mind how long the person stays or what's done for them. We'll pay so much for a particular illness episode. In the case of capitation, we'll pay so much per year regardless of whether the person goes to the hospital or not, regardless of whether they use medical care or not. These are all forms of global reimbursement.

The third change is that the reimbursement is prospective rather than retrospective. In the past, the bill was submitted based on the costs that were incurred. Now, third-party payers are saying that they want to know in advance how much it's going to cost. They want to bargain, in advance, over the price per diem, the price per stay or whatever it happens to be. This is sometimes referred to as the end of cost-based reimbursement. That is a bit of a misnomer, because costs always play a role in price determination. The difference is that the prices are negotiated in advance and the payments are arranged prospectively.

The fourth change is evidenced in a growing role for the consumer. The consumer has to make more choices. Instead of having one plan provided by the employer, now the consumer has to choose between a Blue Cross plan and an HMO and a PPO and several other alternatives. Even at the point of service, with the increasing use of deductibles, coinsurance, and PPO systems with varying rates of coinsurance, the consumer is playing a more active role now than ever before.

Along with all of this comes a push towards larger organizations. Paul Elwood says that by the year 2000 there will be only twenty corporations in America running all of medical care. I think that's a horrible thought.

Why this tremendous push toward larger organizations?

Firstly, there's insurance risk-sharing. The physician is being asked to bear more of the financial risk, to take more financial responsibility for the total cost of care. But individual physicians and even small groups of physicians cannot bear that risk. So they have to be organized, they have to be part of larger organizations, if only just from the point of view of insurance.

Secondly, there's marketing. You have these big third-party payers coming in and they want to bargain with somebody, and you need to have the apparatus to bargain with them. And you need to have a little clout, a little power to bargain with them. There is competition out there, as you well know, in every big metropolitan area in this country. That means you need marketing skills and marketing managers.

Thirdly, finance. Medical care today uses a lot of expensive capital equipment, whether in the hospital or outside. You need to have access to capital markets. You

need to be able to obtain capital at reasonable terms, and again, the advantage is with the larger organization.

Fourthly, red tape. The growth of government regulation means a tremendous amount of paperwork, a tremendous amount of negotiation and dealing. As I like to say, it takes a bureaucrat to fight a bureaucrat. That means you need to have organization.

It may not have escaped your notice that in all this, I haven't said anything about taking care of sick people. That's fairly deliberate, because large organizations don't really take care of sick people. Taking care of sick people often involves one physician and one patient. A hospital with 200 or 250 beds is probably more efficient than a 1,000 bed hospital. So we're not talking about an industry like automobile manufacturing, where there are tremendous economies of scale. There aren't tremendous economies of scale in the production of good medical care. But there are these other considerations of finance, marketing, insurance and so on.

There is one real efficiency that I've observed in larger groups: they make much more efficient and rational use of specialists and subspecialists. A large organization, like a Mayo or a Kaiser Plan, will have the specialists and subspecialists that they need to take care of their patient load and patient population.

But in the community at large, of course, the situation is very different. I'll illustrate this from a field that I've studied many times, general surgery.

General surgeons abound. A national study about 15 years ago showed that the average surgeon performed the equivalent of about three or four herniographys a week. Those of you who are in medicine, in surgery, can appreciate exactly how much work that entails. You go into a prepaid group practice like Kaiser, or a group health cooperative up in Seattle, and the average surgeon will be doing nine or ten herniography equivalents a week. Go into a place like Mayo, which is really organized, which has surgical assistants and several operating rooms, and the average general surgeon is doing about 15 herniography equivalents a week. That's a tremendous difference. Out there in the community, anybody who wants to can set up shop. But there isn't that much business around to keep them all busy in this specialty.

Now, Mayo is an interesting case because, if you look at the biography of the Mayo brothers, you'll see that at a very early stage they recognized the need for management and managerial skills.

They said, "We're physicians. We're good at taking care of sick people, but we don't know how to run an organization. We're going to bring in people to run the organization for us. They are not going to tell us how to practice medicine, but they are going to run our organization." That's exactly what they did and if you go into Mayo today, you'll see that there are managers in positions of authority and status.

I was explaining this in a class one day at Stanford and one of the students said, "Professor Fuchs, you've got one thing wrong." He said, "I did my residency at Mayo and I want to tell you that at Mayo, the physicians think that they're running things." I smiled and replied, "Thanks, that's exactly my point."

Mayo is a $300 million-a-year organization and it's run efficiently and smoothly and profitably. And if you think practicing physicians are running a $300 million-a-year organization themselves, you're kidding yourself. But if the practicing physicians think that they still have the power and so on, that's great. They are revealing that, for the things that matter to them, there hasn't been any interference. They feel good about what they're doing. But I assure you that there are professional managers out there running that $300 million-a-year organization.

What I'm leading up to, really, is that physicians have to put aside, once and for all, the notion of remaining in complete control, of having complete power over things. That's not going to be.

Physicians have to decide what's really important. What is it that we don't want interference with and how can we delegate the other responsibilities to other people and give them real power, give them real authority? Because otherwise they're going to take it away.

Physicians have to decide what's really important. What is it that we have to maintain control over? What is it that we don't want interference with and how can we delegate the other responsibilities to other people and give them real power, give them real authority? Because otherwise they're going to *take* it away. Work out a compromise between the managers who are here to stay. I don't mean to suggest for a moment that this is going to be easy. All kinds of conflicts develop. There are conflicts between the physicians and the managers. There are going to be tensions between the pull to do what's good for the patient, and the interests of the organization, the group, the hospital.

Fortunately or unfortunately, depending upon your point of view, there is room to maneuver. There's room to maneuver

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because so much of what is being done today, and what has been traditional practice, has been inadequately evaluated. It isn't as if we know that everything that's going on now is right and is indispensable. Not at all. Every day in America, we spend about a billion dollars for health care. Every day! Saturdays and Sundays included. Some of that care is of tremendous value. Deaths are averted, pain is relieved, functions are restored. But some of it does more harm than good. And sometimes we just don't know if it's doing good or doing harm or just neutral.

I'll give you some examples. For 30 years patients admitted to hospitals on the east coast have, on average, stayed one to two days longer than patients with exactly the same diagnosis on the west coast. And that's true, diagnosis by diagnosis. Why? Nobody knows. I've tried hard to find out and I still don't know. Does it do the patients any good on the east coast to stay that extra day or two? I don't know.

Another example: patients who are covered by conventional insurance—Blue Cross, Prudential, whatever—have a rate of admission to hospitals 50 percent higher than people of the same age, sex, occupation, and so forth who belong to prepaid group practices. They have a 50 percent higher admission rate to hospitals. Do those extra admissions to hospitals improve the health of those people? We just don't know the answer.

I've talked about the growth of organizations and I've talked about the fact that some power has to be shared. I must tell you frankly, I would be very sorry to see all the power slip away from the physicians. When people are sick, they don't want to see insurance company managers, they don't want to see economists, they don't want to see politicians. They want to see doctors. I think that it is very important that physicians keep a certain amount of power, a certain amount of control over what happens.

How can that be accomplished? The very first thing is to recognize the legitimacy of the concern over costs. As long as you keep your head in the sand and think that these are illegitimate or ill-conceived or irrational concerns, you will never be able to survive. So you must first of all recognize the legitimacy of the problem.

Secondly, mount a nationwide effort to find out what part of the budget matters and what doesn't. In that billion dollars that we spend every day, is there room for cutbacks, savings that do not jeopardize the health of patients? Only physicians can find that out. No one else can begin to develop the answers to that critical question. You should come forward with positive programs that contain costs and serve the needs of patients.

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It's no use waiting for whatever strikes next, be it a given regulation or some kind of movement from the insurance industry. It's time for physicians to assert themselves in a positive way, not simply in a reactive, defensive way.

Will physicians be as well off as before? I can't promise you that. In fact, I can probably promise you the reverse, that no matter how hard you work and no matter how intelligently you pursue these matters, the golden age—the age when physicians had complete control and the money rolled in fairly easily—is not going to come back. But can intelligent and courageous action make a difference? Yes, it can make a difference. If you have a good understanding of what's happening, if you have a good understanding of why it's happening, if you have the fortitude to accept those things that can't be changed and the courage to change those things that can be changed, if you're smart enough to know which is which, you can make a difference.

I began by talking about a revolution, and every revolution has within it the seeds of its own destruction. This one in health-care finance is no different, because the problems that it addresses are very probable, very real. Overutilization of services, inadequate evaluation of technology, inefficient and inequitable cross-subsidization, excess supplies of specialists and hospital beds—these are real problems. They weren't invented by anyone in Washington or anywhere else. This revolution is trying to address those problems, but it will also bring new problems in its wake. There'll be millions of people with inadequate insurance coverage. There'll be the possibility of the erosion of professional ethics as an instrument of control. There'll be a weakening of the trust between physicians and patients and the falling away of a lot of the cooperative, positive efforts that have characterized medicine and hospitals in the past.

What we've got to do now is to recognize the situation, recognize the seriousness of it, and really come to grips with it in a positive and constructive way.

FRANKIE TRULL

The Changing Climate for Biomedical Research

I'm here today to talk about a very difficult issue: the use of animals in research, and its relationship to biomedical research funding. I think it's fair to say that America's biomedical research enterprise is the envy of the world. Our unique combination of publicly funded research in the biological sciences and privately financed research and product development has produced innumerable scientific advances and medical breakthroughs.

That system, however, is now in jeopardy. Proposed federal budget cuts threaten to greatly reduce the number of grants awarded by the NIH, the single largest supporter of biomedical research in the United States, from 6,000 to 4,500. I think you are all aware of that, but what you may not know is that those cuts are currently before the Department of Justice for ruling. That means David Stockman may have gotten what he wanted anyway because it will have been delayed into the next fiscal year.

Social forces, namely widespread public antagonism toward research as manifested most vigorously by the animal rights movement, constitute an equally formidable threat to the research enterprise. For research is dependent upon public support, both moral and financial. The confluence of these economic and social forces bodes ill for the nation's biomedical research laboratories, particularly those on university campuses, where most biomedical and basic research takes place. As everyone here is aware, academic medicine and biomedical research are not spectacularly lucrative occupations. The competition for grants has always been intense. Research costs have climbed steadily. Salaries drawn from grants are notoriously low and universities lack the resources to supplement them adequately.

They are too well aware of the disparity between the rewards of publicly funded research and the often superior working conditions offered by industry.

Much of the reward keeping biomedical researchers in the laboratory is psychic. Intellectual challenge, the esteem of peers, the belief in the importance of the work and in advancing scientific knowledge and benefitting mankind—these are the rewards, often intangible, of a research career. Even intangible rewards, however, must be secured with dollars, mostly public dollars. And public dollars, taxpayer dollars, must be underwritten by public support for research. When one or both forms of that support erode, the results can be dire. Recently, the *Wall Street Journal* chronicled the depression that is sweeping medical research as a result of the NIH budget cuts. Threats of tenure loss, layoffs and careers short-circuited by lack of funds are already taking their toll on researchers. They are too well aware of the disparity between the rewards of publicly funded research and the often superior working conditions offered by industry. Adding to that depression, I would wager, is the erosion of public support for biomedical research, particularly for research with laboratory animals.

The animal rights movement, the most visible manifestation of that erosion, may seem at first blush to be a body of cranks whose noisy claims of torture and murder in the laboratories are unworthy of concern. They may appear to be somewhat deranged antivivisectionists best dealt with by ignoring them. In reality, however, the animal rights movement has emerged as a formidable threat to every institute that's engaged in biomedical research. The attack on research with animals is emotional and irrational certainly, but it has also become alarmingly effective. Its advocates are neither fools nor amateurs. They may be crazy, but they are far from stupid. Their arguments may be naive, but their methods are highly sophisticated.

Since 1975, a handful of cranks has coalesced into a grassroots movement of more than 200 organizations and more than two million activist adherents. And by activist adherents I mean people who send in their dues every year to these animal rights organizations.

Over the years, they've become increasingly adept at manipulating the media. They are shrewd students of popular psychology and popular prejudice. And in their highly skilled propaganda, in the worst sense of the word, they have the

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The American people have a voracious appetite for medical miracles. Unfortunately, they don't have the same hunger for information on the scientific process, how biomedical breakthroughs come to pass, the years of work, the innumerable steps that must precede a medical discovery.

power of the lie. They exploit popular ignorance of the scientific process. They mine the vein of antipathy towards science that is buried within our society today. Scarcely a day goes by when we don't read in newspapers of medical breakthroughs achieved through research. Even the earliest findings on a medical problem are reported in the popular press and highlighted on television and radio. The American people have a voracious appetite for medical miracles. Unfortunately, they don't have the same hunger for information on the scientific process, how biomedical breakthroughs come to pass, the years of work, the innumerable steps that must precede a medical discovery. In short, Americans are more interested in the scores than they are in the ballgame, the intricate and skilled plays that add up to a scientific victory.

A good portion of the American public, including their elected representatives, cannot follow the scientific process even if they want to. Scientific illiteracy abounds. As Donald Kennedy, President of Stanford University, noted, the U.S. lacks a system of scientific belief. Astrology is taken as seriously as astronomy. Mysticism is accorded the same respect as rational analysis. Disease is often viewed as God's visitation on the unworthy, not an inherent part of human existence.

Many people believe that it is good to have ideas, and that all ideas have equal merit, whether or not they are rooted in fact. Another prevalent belief is that biomedical science is big business and, as such, is not to be trusted. In an era of fiscal and political conservatism, the research enterprise appears to be haphazard, even wasteful. The academic definition of research productivity translates poorly to a public that demands management by objective. It comes down to the question, What are we getting for our money anyway?

The criticisms leveled against the last decade's war on cancer, which made slow progress, are a direct outgrowth of this type of thinking. If one researcher can produce a medical breakthrough, then what are all those other guys doing? Publishing articles in scientific journals that no one can read is not the public's notion of productivity. All too often, researchers are perceived as grant-happy leeches, pursuing obscure and irrelevant scientific investigations at the taxpayers' expense, and getting rich in the process. These attitudes would be troubling enough without the animal rights movement.

But the fact is, the current environment has provided fertile ground for those who seek to eliminate biomedical research with animals. Not only have they shamelessly exploited popular sentimentality over animals, but they've also called into question the very nature of the scientific process. They have challenged the liberal credo that the acquisition of knowledge for its own sake is a worthwhile human undertaking. The old-fashioned antivivisectionists are now dressed for success in the garb of contemporary know-nothingism. They prey upon the affection for pets that marks our affluent society. They pander to the popular belief that medical problems can be easily solved. They capitalize upon the fact that most people now live long, relatively healthy lives. They are trying to persuade the public that research itself is unnecessary, that all we have to do is stop eating meat in order to eliminate disease.

The animal rights movement has raised doubts in the minds of the public and their elected representatives. They question why animals are necessary to so many research projects. They feel that animals are often abused or mistreated. They're unaware of, or dissatisfied with, the current laws, regulations and guidelines that protect research animals. The animal rights movement has aggressively and often successfully exploited these attitudes in lobbying at the federal and state levels. And I can tell you, as someone who represents the biomedical research community on legislative issues, that their lobbying powers are really extraordinary.

A bill is now pending in Congress, introduced by Congressman Torricelli, a Democrat from New Jersey, called the Information Dissemination and Research Accountability Act. That bill is based on the premise that 80 to 90 percent of the research done in this country is duplicative and, therefore, unnecessary. Ergo, it recommends the establishment of a major computerized information dissemination program. Anybody who wants to submit a grant proposal must first do a worldwide literature search to insure that this research is not going on anywhere else in the world. Several estimates were made on the costs of that bill. It rivals the NIH budget. It would cost more than $4 billion to implement that program. So, you say, how ridiculous. I'm here to tell you that there are more than 50 co-sponsors in Congress of that piece of legislation right now. It exists because there is a tremendous misunderstanding on the

part of the public about biomedical research, what it means and why we have it.

One program and one program only in the federal government inspects research facilities: the Animal and Plant Health Inspection Service of the Department of Agriculture. It does so under the authority of the Animal Welfare Act, the only federal statutory authority to inspect research facilities. So Mr. Stockman, in his infinite wisdom, has recommended that that inspection program be eliminated totally and that the responsibility for inspection of research facilities be taken over by the individual states, industry and humane societies. In fact, it undermines public confidence to have the federal government say that someone else should worry about the inspection of research facilities. So we are, of course, lobbying actively to have that money restored. APHIS responsibilities also include inspection of every licensed research facility, every licensed animal dealer, every licensed exhibitor. They are supposed to inspect every research facility nationwide between two and four times each year. For that purpose, they have only $4.8 million. Yet the Administration would like to eliminate this program.

The major effort on the part of animal rights groups is to have more involvement in your research protocols, in how you determine what kind of research you're going to do, and whether or not you should be funded.

You should know about other federal breakthroughs, including the pending introduction of new Public Health Service policy changes. Everyone who receives NIH funding will be affected. Among other things, more stringent controls between NIH and the research facilities will insure that the NIH Guide for the Care and Use of Laboratory Animals is being followed. Beyond that, there will now be an outside representative on every animal care committee, at every research facility. That person is defined, in the Public Health Service policy changes, as a nonaffiliated person whose sole responsibility or connection to the research facility is to be an active member of this animal care committee. Mr. Brown will momentarily introduce his amendments to the Animal Welfare Act, and if they pass, the definition would go a step further. His amendment says the outside member will represent "society's concerns regarding animal welfare." We believe that implementation of the PHS policy changes will increase the public's confidence in the research use of laboratory animals.

The major effort on the part of animal rights groups is to have more involvement in your research protocols, in how you determine what kind of research you're going to do, and whether or not you should be funded. When the Administration proposed to cut NIH's budget in relation to these grants, many animal rights organizations recommended to their members that they send telegrams to President Reagan applauding him for the NIH budget cuts. But what they said was, "Don't mention anything about laboratory animals. Just applaud him for his cost-cutting measures. But the real reason you're supporting those cuts is that they will result in having that many fewer animals tortured in biomedical research." Not taking their techniques and their tactics seriously is, I think, a mistake.

We are also seeing much more activity on a state level than we have in the past. Right now, we are tracking about 100 state bills that would directly affect the use of animals in research. The most prevalent target is the use of pound animals in research. Many dogs and cats in this country are not claimed by their owners. They are unwanted, unclaimed stray animals. Animal pounds and shelters in this country kill 10 to 15 million dogs and cats every single year. This amount—10 to 15 million—is almost one third of the entire pet population, I might point out. Biomedical research uses approximately 138,000 dogs from pounds in research and education every year. And the pounds kill 10 million. Medical schools depend very heavily upon the use of pound animals for both research and education, and pioneers like Michael DeBakey and Norman Shumway have stated that many of their advances in cardiovascular surgery were derived from research that included pound animals. But it's a highly emotional issue. People say, "Oh my God. Pets are being used in research." Clearly these 10 to 15 million animals are not people's pets. But the animal rights groups have gathered around this particular issue because of its emotionality. They feel that they can win on this issue. And if they can win on this one, it's the first foot in the door. Historically, medical schools did not take this as seriously as they might have. So in 1983, Massachusetts was confronted with legislation saying that not only could the medical schools not use pound animals from within the state, but they could not import pound animals from other states. The medical profession decided to compromise with the animal rights groups and agreed to have that piece of legislation passed, because the animal rights groups promised to go away after that. The bill was signed by the Governor and the

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next day there were full-page ads in the *Boston Globe* with a picture of a dog wearing a helmet; the caption read, "We have won a major battle, now help us win the war." So you cannot underestimate the fact that they are going to go all the way with this. This is no longer an issue of cruelty to animals, with which, of course, we're all concerned. These people say that animals have rights and we have no business exploiting those rights.

Unfortunately many people feel that legislatures, whether federal or state, work too slowly, so they resort to violence. An underground organization called the Animal Liberation Front is an extension of a movement in the United Kingdom. By underground, I mean that it's not incorporated. You aren't going to see it officially listed anyplace. These are terrorists who break into research facilities and damage property and steal animals. The most recent incident took place last weekend at the University of California-Riverside, where they stole approximately 400 animals. They smashed computers, they trashed laboratories, they spray-painted graffiti on the walls. By the most recent estimate, they did more than $600,000 worth of damage. Several months ago they broke into the City of Hope in Duarte, California.

How do we convince the public and its legislators that humane and responsible research with animals is essential to medical progress? One critical factor is the participation of the research community itself in a public education effort.

For those of you who are in medical schools, and I think most of you are, all of these break-ins are inside jobs. Personnel are feeding the information out to animal rights activists.

Anyway, back to the legislative proposals. If any of them are adopted, the bottom line is going to be an increase in cost, and it will clearly have a major effect on how you use laboratory animals and how you conduct your biomedical research. The result, particularly in an area of shrinking budgets and vanishing champions of research, will inevitably be a further reduction in the number of projects undertaken. In fact, there are those animal rights watchers in the research community who believe this is the real agenda of the movement. They intend to price animal research right out of existence.

Beyond finances, the animal rights movement is having a detrimental effect on the image of research and those who conduct it. Many members of the media with whom the Foundation for Biomedical Research has dealt have openly voiced their dislike and distrust of researchers. "Arrogant" is the epithet applied most often. The research community is perceived by them as a kind of priesthood, a cult that operates behind closed doors, one that has no accountability to the public whose dollars funded the work.

This attitude is evident to us every day, in the biased manner in which the media generally reports the activities and charges of the animal rights movement. The tone of the coverage implies that researchers are getting what they deserve.

How, then, do we change the situation? Can we stem the erosion of popular support for biomedical science? How do we convince the public and its legislators that humane and responsible research with animals is essential to medical progress? One critical factor is the participation of the research community itself in a public education effort. All too many members of the research community choose to dismiss the insidious threat posed by the animal rights movement. Hoping the issue will go away, they discount the movement as a bunch of ineffectual old ladies in tennis shoes. Others feel, with some justification, that fighting such irrational issues takes time and energy away from their work. Equally justified, however, is the fact that unless this threat is blocked, there may be less and less work to do. Still others are simply uncomfortable with the whole idea. At a time when the research enterprise appears to be undergoing a devaluation by society, having to defend the morality or the necessity for research methodology may simply be the last straw for discouraged researchers.

No one enjoys experimenting on animals. When your character and ethics are attacked because of it, any ambivalence you may feel may be heightened. But it is precisely that ambivalence, defensiveness and passivity that the animal rights movement is counting on. They hope that every salvo they fire will drive the research community deeper into its entrenched position of not communicating with the public. Their desire is that researchers become less and less articulate about the nature and importance of their work. Too much is at stake for science and medicine, for research institutions and medical associations, to ignore this issue. In today's increasingly hostile environment, no one can afford to pretend that it's business as usual. The future of biomedical research is going to be determined by the public, whether we like it or not. Thus, it is in our best interest to do all we can to see that public policy decisions on research are made by an informed public, by informed legislators. Ignorance, preju-

But we cannot address this complex issue alone. We need your help. . . . As physicians you have direct contact with that grassroots network, the patients. Researchers do not have the same direct access that all of you have.

dice and a misplaced sympathy for animals cannot be allowed to jeopardize the future health and well-being of humans. In essence, that is the work of the Foundation for Biomedical Research.

The Foundation was established three years ago. We are funded primarily by companies and academic institutions involved in the use of animals in research. The pharmaceutical industry has been particularly generous, but universities also give us a substantial amount of money. The Foundation has a series of educational tools and a public relations firm, which is headquartered in New York. We know that biomedical researchers are not trained as professional communicators and so we offer that kind of professional assistance. We have a speakers bureau, and we've media-trained a number of physicians around the country who go on television and radio to discuss the issue. Often they appear with their patients, who tell how their lives were saved as a result of research. These patients, who have benefitted from the results of biomedical research, are a grassroots network that is really stronger than that of the animal rights movement.

But we cannot address this complex issue alone. We need your help. We need the support not only of your medical societies but of the foundations which I think many of you represent. You can't hide. Silence translates into guilt. You need to communicate to the lay person. And as physicians you have direct contact with that grassroots network, the patients. Researchers do not have the same direct access that all of you have.

There's no magical way to win on this issue. But win we must. And win we will, if all of us do our part, both individually and collectively. Remember that the struggle is not merely to secure the hegemony of the research community. The real winners or losers in this battle of ideas will be the millions of human beings around the world whose health and well-being it is our business to improve.

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DAVID DURENBERGER

Redeployment of Resources in Health Care

I'm from the government and I'm here to help! My address is Senate Russell Building 154, Washington, DC 20510. My telephone number is 224-3244. And I'm never in.

I noticed, when I arrived in Washington from Minnesota, that a lot of people were wondering why Minnesota produced such talented people in government service (that's before they got to know me). They talked about Humphrey and McCarthy and Mondale and people like that. I've recently concluded that it's because, to some degree, we're all like sponges. We go around the country, we go around our communities, and we absorb things. In other words, we have two ears that work and something in between, for the most part. And as we learn things, we try to change them.

For those of you who wonder why consumer choice began in Minnesota and is now spreading across the country, and why other innovations in public policy start with Minnesotans, I think it is, in large part, because we have the ability to go from one place to the other and begin squeezing out our sponges, which is what I'm going to do now—sharing with you people something I've learned elsewhere.

I've been on the Senate Finance Committee ever since I arrived in the Senate. I became Chairman of the Health Subcommittee in 1981 and I'm still there. I'm on the Governmental Affairs Committee in charge of intergovernmental relations. I'm on the Environment and Public Works Committee, in charge of toxic substances and environmental oversight. I'm also Chairman of the Senate Intelligence Committee.

Many people probably don't know that the Senate has an Intelligence Committee. You probably assumed that I won the IQ contest or something like that in order to get in. You'd really be surprised to know that last year I was also on the Ethics Committee—in case you also had certain presumptions about senators in that regard.

You may have heard the President tell you that this economic recovery could keep going if only we could reduce government spending. And the only way we can reduce government spending is by getting Congress to have the courage to believe that Jack Kennedy was right, not just when he cut taxes and improved the economy, but when he said in 1961, "Ask not what your country can do for you, ask what you can do for your country."

I do not use the quotation to indicate that you should go back to your communities, and find ways to help your country. In a sense, right now, there are probably too many people helping their country. There are 535 of us in the Congress with 535 different views on how to help the country. That's not necessarily the best way to get anything done.

Clearly, the election of 1984 marked a resounding end to an era. And since anything that ends has to be replaced by something new, I will assume there is a new beginning. I hope to now give you a feel for what some of the new issues that you will need to deal with are going to be.

You can look at this new beginning in a variety of ways. You can go back to the 1984 election and say, "What did we learn from that? What did we express, as a people, in that election?" As I now face such issues as the budget, tax reform, and Nicaragua, I look back at that election and ask, what did it tell me, as a messenger for 232 million people?

I've concluded that the primary message of that election is that people trust the incumbent President. They think that Ronald Reagan can do a better job than any of the alternative candidates in national security, domestic policy, economic recovery, or even just making you feel better about yourself in 1988 than you do in 1984.

The election was based more on general feelings than on specific issues. Because while we decided that Ronald Reagan could improve national security, most people don't believe that it has to cost $285.7 billion just in defense spending to accomplish it. By a margin of about two to one, people do not agree with the policy of providing arms for folks they've never met in

The election was based more on general feelings than on specific issues. Because while we decided that Ronald Reagan could improve national security, most people don't believe that it has to cost $285.7 billion just in defense spending to accomplish it.

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the jungles of northern Nicaragua, in order to save the hemisphere from Soviet communism or the people of this country from being invaded by Central American refugees.

The point is, we didn't decide any of the "how to's" in that election. The debate was not over DRG's. The debate was not over consumer choice and competition in health care. The debate was not over any of the really tough issues. Go through the whole budget today and find out if Amtrak was an issue, if soil conservation was an issue, if the Job Corps was an issue, or if school lunch programs were the issue. None of those things were the issue. They weren't even talked about. For most of us, the election was a question of "How do you feel?" And if you replied that you feel better than you did in 1980, the advice was to vote for more of the same.

What is more of the same? The President's message is that more of the same means less government. It means "Ask not what your government can do for you, because it costs too much and produces too little. Ask what we can do for ourselves."

You can carry that to the extreme, as some people do, and say we don't need government. If we're not supposed to ask government to do anything for us, then why do we bother to have a national government? Well, we're stuck with the Constitution and the Constitution says we have to defend the shores, promote the currency, save ourselves from pirates, that sort of thing.

There are enough people around who believe that what's going on in this country today is, in effect, the dismantling of government.

Some people ask, "Haven't we done a lousy job with welfare? Aren't we wasting $100 billion a year on federal welfare programs being administered through state and local government?" These people would say that the answer to that problem is to get the federal government out of it. "Poor people are not a federal responsibility," they say. "Responsibility for the poor falls somewhere between the churches and the local government."

I'm here to argue that the President and I need you very much. We need you more now than we have ever needed you before. This deficit has, in large part, been deliberately created because you, as taxpayers, have denied me the access to the resources that I need to help you resolve your needs in one way or another. You have done that because you concluded a number of years ago that the way I spend your money is very inefficient, that having 500 federal government programs dictating 1,000 state or local programs is very inefficient. So you bought into the notion that the way to shape us up here in government is to cut off our water.

I recently spent three hours as part of a small group debating with Dave Stockman over how to handle Medicaid in the budget. Dave's bottom line is that, unless we cut off the water to the states, we aren't going to get them to change the way they do business. He made no mention of the poor, no mention of the indigent, no mention of the fact that the Medicare program is driving the elderly into poverty just so they can get into the Medicaid program, or get into nursing homes. No. His philosophy is that the only way to get the states' attention is to cut off their water. The Federal government has a $225 billion deficit, while the states are running surpluses. Ergo, we cut off the states' water. No mention of the poor in all that. That is the kind of oversimplified environment in which we live.

The deficit has been created by all of us in order to get government and/or society to clean up its act.

I am a product of the previous generation. My folks' generation lived through the Depression, when they were suddenly wiped out. No matter how hard they worked to save for a home, and provide a foundation in work and investment savings for me, they got wiped out. And they resolved never to live through that again.

In the post-World War period, they gave my generation the opportunity to have, without paying for it. For 30 years I have been the beneficiary of that system. And therein lies the heart of our problem. We are products of the "have generation."

My parents' generation told me that when I was old enough to marry and have children, I could have a home for a down-payment of $500. I could have a three bedroom home in the suburbs, get away from all the problems of the city. I could have a recreation room in Minnesota, two fireplaces, and an acre of land. And I could have all that for $500. That's all! Five hundred dollars down, a five percent interest rate, paid out over 30 years. And with all the interest deductible on my income taxes, it didn't cost me anything. Once my generation caught on to that, you can imagine what happened. The demand for housing far exceeded the supply and you know

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what happened then. It's the basic economic theory: when the demand exceeds the supply, the prices go up. We found ways to make carpenters rich and forest products people rich. Everybody got rich beyond their wildest dreams, because we took the price of housing right through the roof.

And we all made money off of it. I could buy my first house for $10,000, turn it around in three years for $20,000, put $10,000 in my pocket, take the same $500, put it down on another one. Three years later, I could turn that in for $50,000, put $30,000 in my pocket, put another $500 down and off I went. Is it any wonder why, in a relatively brief period of time, we have priced my children out of housing? They can't afford it. Maybe the top 10 or 15 percent can, but that's it. Without the tax subsidies and without all the other subsidies that go into housing today, you can't afford to own a home.

And it isn't just in housing. We did the same thing with the cars in the garage. You know, you want two or three cars in the garage. It's the average American dream, not just to have transportation, but to have two or three cars. Then, of course, with the interest deduction and what not, we could just recycle those things every three years and get a new car. Did you buy quality? No, you bought chrome. We didn't worry about quality because we could recycle it, turn it in for another one. It wasn't until we got into energy problems and environmental problems, until we discovered Japanese competition, that we stopped making deficient articles. Suddenly, it was better to buy Japanese than to buy American.

We went through the same thing in health care. A few years ago, doctors used to blame the high cost of health care on Medicare and Medicaid. Doctors aren't doing that anymore. The public, unfortunately, is still blaming doctors and hospitals for the high cost of health care. But I'll bet that in a couple of years, they won't be doing that either.

The blame lies with a very well-intentioned society that said everybody ought to have a free health insurance plan.

You're not putting that blame on the government anymore because you know where the blame lies. The blame lies with a very well-intentioned society that said everybody ought to have a free health insurance plan. And the best place to get that is through your employer. If the employer just paid cash, the worker would consume it, because the whole society revolves around consumption. He'd buy a car, food, or vacation; he *wouldn't* buy health care or retirement. So the fringe benefit became the way to get the worker to do things that he wouldn't have done for himself. Every employer said "here's your health insurance." You didn't even have to ask for it. And you didn't read the policy because you couldn't understand it. But what you did understand is that any time you didn't feel well, you could call a doctor and go down and consume his time and his resources without consuming anything from yourself except time. And if you didn't like the advice he gave, you'd go find another doctor. It didn't mean anything. It was free. It was a check drawn on the U.S. Treasury and on your employer. Everybody knew they were covered. They smoked, they drank, they rode their motorcycles without helmets, their automobiles without seat belts, and they ended up as society's problem.

You reacted to that, predictably, by constantly improving the quality of the health care, by constantly improving the number of doctors and the availability of hospitals, by constantly expanding the frontiers of new technology, by constantly specializing to provide the best for Americans, regardless of cost. There's nothing wrong with that. It's typically American. But is was the demand that drove up the availability and the cost of those services. Unlimited demand meant the need for more doctors. It meant having a hospital in every town for the convenience of every home, whatever the consequences to our lifestyle.

At that point in time, we fortified the notion of a national health insurance system, and I know the AMA has been against national health insurance ever since Teddy Kennedy came to office. But we've had it in this country. It's called: the doctor never turns anybody away. I like to use the illustration of Biwabik, Minnesota. If you got sick in Biwabik years ago, you came and knocked on the doctor's door in the middle of the night. The doctor's wife came to the door and said, "Oh, hi Tilly, how are you?" "Oh," Tilly says, "I have some horrible pains." "Well," the doctor's wife says, "come on in and I'll wake up Mike." So she wakes up the doc, and he comes and he sits there and talks, and then he makes a decision. He is either going to treat her on the spot, or he's gonna put her in the hospital overnight. That was the community hospital. Nobody every refused to open the door, and the poor doc was stuck there 24 hours a day. That's why he left Biwabik and went to the bigger cities.

The point is, we've always had that kind of a national health insurance system in America, and it's been community-based. When we couldn't pay for it with cabbages and pickles and sides of ham, we created taxes, and the church took part in bingo parties to pay for it.

But when we increased the cost of the doctor opening the door, and we increased the demand for the best in hospitals, the Biwabik Hospital become a nursing home. And everybody went to the next town where they had the Miners' Hospital, paid for by the iron-ore industries. It was a beautiful hospital and just by looking at it you'd feel you'd get better care there than in Biwabik.

But with this sort of unlimited demand and this need to have treatment, the prices for the doctors, for the hospital, for specialization and everything skyrocketed, just like housing prices. When it reached a certain point, we had to find ways to subsidize it other than by the so-called national health insurance system, whereby everybody who comes in the front door gets taken care of. And at that point, we adopted a system for the elderly, the disabled and the poor. We said, "If you can get health insurance by going to work, why shouldn't you be able to get it when you're elderly, disabled or poor?" So we created Medicaid and Medicare on the same model.

But we made the same mistake. The beneficiaries didn't pay for it. The worker didn't pay for his own insurance. Instead, we found a way to make the worker pay for somebody else's insurance, like Medicare and Medicaid, either through their taxes or through something else. What a strange system. We didn't want to cause anybody *not* to have coverage, and we were afraid that people might not want to have it if we said they had to pay for it. So we had a system in which I would pay for somebody else, and somebody would pay for me.

Where was the constraint? Well, it wasn't there until we reached something over $300 billion in total Medicare/Medicaid costs. Then all of a sudden we started putting the brakes on. And we put the brakes on in the same way we put the brakes on the politicians: "We're going to cut back on your money."

Well, change is coming. The answer lies in responsibility and consumer choice. I ought to have the opportunity to know that if I don't smoke, don't drink, and wear a safety restraint in my automobile while I'm driving, it pays off someplace. It should pay off when I buy my automobile insurance policy, or my life insurance policy, or something. There should be some price tag that says "You are hereby rewarded by society for maintaining your health, for avoiding the risk of an accident." We're just at the edge of that today.

Change is coming. The answer lies in responsibility and consumer choice. I ought to have the opportunity to know that if I don't smoke, don't drink, and wear a safety restraint in my automobile while I'm driving, it pays off someplace. . . . There should be some price tag that says "You are hereby rewarded by society for maintaining your health, for avoiding the risk of an accident." We're just at the edge of that today.

That's one part of consumer choice. The other part is related to a choice of health plan. When I go to work, don't hand me a policy that I don't understand. Involve me in the consequences of my health. Give me an opportunity to make a choice of health plans.

And it is that part of the system that is growing in this country. That's what's giving you the HMO's and the PPO's and the IPA's. It's individual choice. The result is that the consumer will one day wake up to the fact that it isn't the doctor or the hospital who's at fault in rising costs. The fault lies with our own individual choices, taken 232 million times, every year. That's where the responsibility lies.

At that point in time, when a light goes on in the minds of enough people in this country, you will see some more realistic approaches to health-care financing on the part of the federal government.

We promised you in the Social Security Reform Act of 1983 that if you participated in prospective pricing in Medicare, we wouldn't try to take advantage of you. Yet all we've done since then is take advantage of you. And we're doing it this year to the tune of $18.5 billion in Medicare reductions.

This year everybody's in the freeze business. The hospitals who were promised a CPI or a medical CPI are not going to get it. They're going to get a freeze. They're going to get the same thing on Part A as they got last year, plus they're going next year from 50/50 cost-sharing on the DRG to 75/25.

Some hospitals will suffer, but that's their contribution to solving this problem. Doctors are going to get another Part B freeze. It saves a billion dollars, though it doesn't indicate that there is any sanity in the way we reimburse physicians in this country. But it saves, and I quote, "$16 billion towards a $195 billion deficit reduction." And you heard the President tell you how important that deficit reduction was, how important it is to increase defense spending by three percent plus inflation, while cutting $16 to $18 billion more out of Medicare, and maybe a billion or two out of Medicaid as well.

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Now I want to get to that part of the system known as "the hospital." The old hospitals took care of the indigent, of medical education, of a lot of other things. But in the price competition that comes with consumer choice, everything has to have a price. That includes medical education, and that includes care of the indigent.

If I want to explicitly finance graduate medical education, I have to decide how much of it is a national responsibility and how much of it may be laid on the individual involved, or on the state government. We've never had to deal with that before, because it was all financed by our various universities, and by all those teaching hospitals. We just buried the prices in there. But now we're going to deal with them, because there is no other choice.

I see what's happening to my own university teaching hospital, in a very competitive environment. It's suffering. But I'm not going to shut down consumer choice in the competitive environment because nobody wants to deal with the quality and cost of medical education. I've been imploring the academic medical community to deal with that issue so that we, in government, don't have to deal with it. We do such a poor job with those things.

The same thing is true of care for the indigent. The federal government has a $225 billion deficit this year, while the states are running a surplus. So who cares about the poor? I care about the poor. But I can't get any more money out of Dave Stockman or Ronald Reagan. So what happens to that 2,054-bed Los Angeles General Hospital, or the Cook County General Hospital? The state legislature isn't going to step up and be counted. What's going to happen to those people?

It's a national responsibility, but you need to know how much we, in the federal government, need you today to deal with that responsibility. I am theoretically out of money, because I have this $1.7 trillion debt, with a $225 billion increase every year. The public is being sold a bill of goods saying that everything the government does is a waste of money. Don't give the government any more taxes, the public says, because they've got a problem.

It is a resolvable problem. Because we take great pride in our health-care system in this country, people are willing to pay more for it. People are willing to step up and be counted. All they need is some leadership, some guidance, some direction. I would argue that they aren't getting those things from up on the top. Maybe that's better, because they ought to be getting it from down where they can hear it, and trust it. And that's where all of you in the medical profession come in.

People are willing to step up and be counted. All they need is some leadership, some guidance, some direction.

1978

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Public

REMARKS BY
SENATOR DAVE DURENBERGER
AMERICAN WATERWAYS OPERATORS
APRIL 17, 1985

THANK YOU. I APPRECIATE THE OPPORTUNITY TO SPEAK TO YOU THIS AFTERNOON. FOR ONE THING, IT'S A GREAT RESPITE FROM THE TERRIBLE CHOICES THAT I HAVE TO MAKE ON THIS YEAR'S BUDGET AND THOSE EXPORT KILLING $200 BILLION DEFICITS.

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AND FOR ANOTHER, I HAVE ALWAYS HELD THE MIGHTY MISSISSIPPI AND THOSE WHO PLY IT AS SOMETHING SPECIAL.

YOU KNOW, PEOPLE OF ALL POLITICAL PERSUASIONS LIKE TO QUOTE WILL ROGERS. FRITZ MONDALE, FRITZ HOLLINGS, PRESIDENT REAGAN AND SCORES OF LESSER POLITICIANS ALL THROW A BIT OF WILL'S PRAIRIE POPULIST'S WIT INTO THEIR SPEECHES. AND, IN PREPARING FOR THIS SPEECH, I TOO LOOKED BACK ON THE SAGE WISDOM OF WILL. BUT, UNLIKE EVERYONE ELSE, I FOUND WILL WANTING.

THERE IT WAS, ONE OF HIS MOST FAMOUS QUOTES, APPLICABLE AND APPROPRIATE FOR THIS GROUP, AND I FOUND IT WANTING. AND, YOU MIGHT ASK, WHAT QUOTE AM I REFERRING TO? THE ONE WHERE WILL SAID, "WATERFRONT, THEY DON'T MAKE IT ANYMORE."

I GUESS WILL NEVER HEARD OF THE CORPS OF ENGINEERS. THEY'LL MAKE ANYTHING IF YOU GIVE THEM ENOUGH TIME AND MONEY.

AND I THINK THE SAME HOLDS TRUE FOR CONGRESS AND ITS APPROACH TO NATIONAL PROBLEMS. IF WE HAD ENOUGH MONEY, WE WOULD GIVE EVERYONE A JOB REPAIRING, REBUILDING OR CONSTRUCTING OUR AGING INFRASTRUCTURE. WE WOULD GIVE THE PENTAGON ALL THE MONEY IT NEEDED TO BUY $700 TOILET SEATS SO OUR GENERALS COULD DEFEND THIS COUNTRY IN COMFORT. WE WOULD GIVE EVERY SENIOR CITIZEN IN THIS COUNTRY A GUARANTEED ANNUAL INCOME ABOVE THE POVERTY LEVEL, INDEXED AT 110 PERCENT OF THE RISE IN THE CONSUMER PRICE INDEX.

EDUCATION, ENERGY AND ENVIRONMENTAL PROGRAMS WOULD ALL BE EXPANDED TO ENSURE THAT OUR CHILDREN'S FUTURE IS AS BRIGHT AS OURS. AND FARMERS, THE PEOPLE WHO MADE THIS COUNTRY WHAT IT IS TODAY, WOULD RECEIVE THE COST OF PRODUCTION PLUS A REASONABLE PROFIT FOR THEIR COMMODITIES, FORTY PERCENT OF WHICH WOULD BE EXPORTED TO FEED A HUNGRY WORLD.

UNFORTUNATELY, AND AS YOU ARE FINDING OUT, CONGRESS HAS NOW FOUND OUT THAT IT LACKS THE FUNDS TO MAINTAIN OUR INFRASTRUCTURE, BUY $700 TOILET SEATS, HOLD EVERY SENIOR CITIZEN'S INCOME ABOVE THE POVERTY LEVEL, EXPAND THE HORIZONS FOR TOMORROW'S CHILDREN AND PRESERVE THE FAMILY FARM. AND THIS DISCOVERY IS A WRENCHING ONE FOR THOSE OF US WHO WERE ELECTED TO IMPLEMENT POLICIES TO CARRY OUT OUR CAMPAIGN PROMISES.

IT IS NOT EASY TO TELL AMERICAN WATERWAYS OPERATORS THAT THE TAXES THEY PAY FOR IMPROVEMENTS IN THE INLAND SYSTEM ARE BEING HELD HOSTAGE BY OMB OR THAT IT WILL BE AT LEAST TWO YEARS BEFORE GRAIN EXCEEDS SILT AS THE NUMBER ONE COMMODITY MOVING ON OUR WATERWAYS. IT IS TOUGH TO TELL SENIOR CITIZENS THAT THE UNTAMPERABLE SOCIAL SECURITY SYSTEM MUST BE TAMPERED WITH. AND IT IS A CRYING SHAME THAT, AS WE CUT, CURB AND GUT OUR CHILDREN'S PROGRAMS, OUR CHANCES OF WEEDING OUT THE WASTE, FRAUD, ABUSE AND IGNORANCE OF PENTAGON PROCUREMENT OFFICERS IS LESS THAN 50-50.

So, as I reflected upon what it was I wanted to say today, the old saying "You don't miss what you had until it's gone" came to mind.

It struck me as a relevant theme to draw on when I speak to groups who, like the American Waterways Operators, have scheduled meetings in Washington to map out a strategy to save an industry or a program

FOR AMERICAN WATERWAYS OPERATORS, YOU'RE TRYING TO PRESERVE THE CORPS OF ENGINEERS OPERATION, MAINTENANCE AND, PERHAPS, CONSTRUCTION BUDGET. BUT I COULD JUST AS EASILY BE SPEAKING TO THE NATIONAL ASSOCIATION OF RAIL PASSENGERS WHICH IS TRYING TO SAVE AMTRAK. OR THE CHILDRENS LOBBY, WHICH IS TRYING TO SAVE THE CHILD NUTRITION PROGRAMS. OR THE FARM GROUPS, WHO ARE TRYING TO PRESERVE NOT ONLY AN INDUSTRY, BUT AN ENTIRE WAY OF LIFE IN RURAL AMERICA.

AND DO YOU KNOW WHAT IT IS THAT YOU AND EVERY OTHER GROUP MISS NOW THAT IT IS GONE? EASY, PAINLESS, ANSWERS.

AND DO YOU KNOW WHAT WIPED OUT WHATEVER CHANCE CONGRESS HAD TO FIND PAINLESS SOLUTIONS? A NEVER ENDING STREAM OF $200 BILLION DEFICITS STRETCHING OUT INTO THE DISTANT FUTURE.

EVERYONE HAS THEIR OWN OPINION ON HOW WE GOT INTO THIS MESS. MY OWN CYNICAL VIEW IS THAT THIS ADMINISTRATION LET THE DEFICITS GET OUT OF CONTROL IN ORDER TO USE DEFICITS AS AN EXCUSE TO DISMANTLE EVERY FEDERAL PROGRAM DAVE STOCKMAN DISAGREES WITH. BUT, THEN AGAIN, I GUESS IT ISN'T FAIR TO HEAP THE BLAME ON ANY ONE PERSON, ANY ONE ADMINISTRATION OR ANY ONE PARTY. BECAUSE, WHILE THERE IS AMPLE BLAME TO SPREAD AROUND TO ALL THE GUILTY PARTIES, YOU DON;T SOLVE ANY PROBLEMS BY ASSESSING BLAME.

RATHER THAN POINT FINGERS, I THINK OUR TIME COULD BE BETTER SPENT TRYING TO FIND A WAY TO REDUCE THE DEFICIT.

AS MOST OF YOU KNOW, THERE IS A RIGHT WAY AND A WRONG WAY OF DOING EVERYTHING, AND REDUCING THE DEFICIT IS A CASE IN POINT.

THE BUDGET RESOLUTION REPORTED OUT OF THE SENATE BUDGET COMMITTEE STRUCK ME AS A REASONABLE FIRST STEP IN CONGRESS' ATTEMPT TO CONTROL SPENDING.

FOR THOSE FO YOU WHO WERE NOT FAMILIAR WITH THE RESOLUTION, IT FROZE ALL DISCRETIONARY SPENDING AT LAST YEAR'S LEVEL, FROZE ALL COLA'S, FROZE DEFENSE AT ZERO PERCENT REAL GROWTH AND ELIMINATED SEVEN PROGRAMS OUTRIGHT. I CALL THAT AN AUSTERE BUDGET.

SURPRISINGLY, EVEN THOUGH THE RESOLUTION DID NOT CALL FOR INCREASED TAXES, THE ADMINISTRATION DID NOT SUPPORT THE RESOLUTION, AND PUSHED FOR NEGOTIATIONS WITH THE SENATE LEADERSHIP FOR A DIFFERENT PACKAGE.

UNFORTUNATELY, THOSE NEGOTIAIONS PRODUCED AN AGREEMENT WHICH STRIKES ME AS THE WRONG WAY TO BALANCE THE BUDGET. MY PRIMARY OBJECTION IS THAT IT IS A BUDGET OF SELECTIVE, AS OPPOSED TO SHARED, SACRIFICE. MANY OF THE PROPOSALS--THE THREE YEAR CUT IN SOCIAL SECURITY COLA'S AND THE SHARP CUTS IN FOOD AND IN AGRICULTURE PROGRAMS IN PARTICULAR--STRIKE ME AS UNSUSTAINABLE. OTHER PROPOSALS, SUCH AS THE 3% AFTER INFLATION INCREASE IN DEFENSE SPENDING, FLY IN THE FACE OF THE FREEZE MENTALITY WHICH PERVADES THE CONGRESS.

BUT, MORE IMPORTANTLY, THE AGREEMENT ESTABLISHES A POLICY OF DISINVESTMENT IN THE PROGRAMS, PROJECTS AND INFRASTRUCTURE THAT WE WILL TURN OVER TO FUTURE GENERATIONS. LET ME CITE A FEW EXAMPLES.

IN INFRASTRUCTURE FINANCING, THE AGREEMENT REQUIRES AN INCREASE IN USER FEES FOR PROGRAMS THAT RELY ON USER FINANCING TO PAY FOR A PORTION OF THEIR COSTS. THE THREE PRIMARY USER-FINANCED INFRASTRUCTURE ACTIVITIES ARE AVIATION, HIGHWAYS AND WATERWAYS.

EACH ONE OF THESE PROGRAMS ENJOY TRUST FUND SURPLUSES WHICH WOULD ONLY INCREASE WITH ADDITIONAL REVENUES FROM USER FEES. BUT THE OFFICE OF MANAGEMENT AND BUDGET DOES NOT WANT TO SPEND THE USER FEE REVENUE ON INFRASTRUCTURE CONSTRUCTION, PREFERRING INSTEAD TO USE THE REVENUE TO COVER OPERATIONS, MAINTENANCE AND ADMINISTRATIVE EXPENSES.

UNDER THE TERMS OF THE AGREEMENT, WHILE THERE IS NO DIRECT STATEMENT THAT BARGE DIESEL TAXES SHOULD BE RAISED, THE ABSENCE OF FUNDS FOR NEW CONSTRUCTION CLEARLY SHOWS THAT IF LOCK AND DAM 26, BONNEVILLE, OR ANY OF THE OTHER MAJOR PROJECTS ARE TO BE STARTED, THE BARGE INDUSTRY AND ITS SHIPPERS WILL FINANCE IT.

How has the barge industry responded? As anyone could predict, your industry, mired in its worst depression in history, has decided to forget about the future and is now willing, because of the threat of user fees, to forego the necessary capital improvement projects needed to bring our inland navigation system into the 21st Century. And what troubles me is that it is our children and grandchildren who will suffer when the 194 locks, which currently average 40 years, collapse.

THE QUESTION THAT I MUST ASK IS WHERE WILL OUR FUTURE GENERATIONS, ALREADY SADDLED WITH THE TRILLIONS OF DOLLARS IN NEW DEBT CREATED BY OUR GENERATION, FIND THE RESOURCES TO RECONSTRUCT AN INFRASTRUCTURE IN DISREPAIR.

AND THAT IS JUST INFRASTRUCTURE. WHAT ABOUT AGRICULTURE--THE WATERWAY OPERATORS MOST IMPORTANT INDUSTRY.

WHERE THE BUDGET RESOLUTION TREATED THE TROUBLED MIDWESTERN FARMERS WITH COMPASSION, THE AGREEMENT REQUIRES MASSIVE CUTS IN CROP PRICE SUPPORTS--CUTS THAT COULD DRIVE HUNDREDS OF THOUSANDS OF FARMERS OFF THEIR LAND, TOTALLY TRANSFORMING THE STRUCTURE OF AGRICULTURE AND THE FACE OF RURAL AMERICA. BUT YOU KNOW, I KNOW AND FARMERS KNOW THAT IT IS NOT THE LOAN RATE WHICH IS PRICING OUR FARMERS OUT OF THE INTERNATIONAL MARKETPLACE, IT IS THE VALUE OF THE DOLLAR.

IT IS THE ALMIGHTY DOLLAR THAT IS KEEPING YOUR GRAIN BARGES IDLE, AND UNTIL THIS COUNTRY HAS A MARKET-ORIENTED MONETARY POLICY, THERE IS NO WAY A MARKET-ORIENTED FARM POLICY WILL WORK OR RECEIVE MY SUPPORT.

BUT HOW WILL FARMERS REACT TO A MARKET-ORIENTED FARM POLICY? THE SAME WAY THE DEPRESSED BARGE INDUSTRY DID--BY DELAYING PURCHASES AND IMPROVEMENTS IN THEIR PHYSICAL PLANT.

FARMERS IN MINNESOTA AREN'T BUYING LAND OR EQUIPMENT AND THEY CAN'T AFFORD TO SELL IT. THEIR ONLY OPTION IS TO GET EVERYTHING THEY POSSIBLY CAN OUT OF WHAT THEY HAVE AT THE LEAST COST. THE FIRST THING TO GO IS SOIL CONSERVATION PRACTICES--THEY ARE TOO EXPENSIVE. THE SECOND THING TO GO IS THE WINDBREAKS, SHELTER BELTS AND TERRACES--THEY CAN BE TORN OUT, CLEARED AND PLANTED. THE THIRD THING TO GO IS THE SOIL, WHICH YOU CAN SEE SITTING UP THE BACKWATERS AND THE MOUTH OF THE MISSISSIPPI.

THE LAST THING TO GO IS THE FAMILY FARMER, WHO JUST CAN'T CUT ENOUGH CORNERS TO COMPETE WITH GENTLEMEN FARMERS WHO FARM THE TAX CODE, NOT THE LAND. AND WHAT DISTURBS ME IS THAT THE SOIL WHICH IS NOW SILTING UP THE RIVERS REPRESENTS THE LOST PRODUCTIVITY OF FUTURE GENERATIONS. AND EVERY TIME WE LOSE A FAMILY FARMER, WE LOSE TOUCH WITH THE LAND, WE LOSE A LITTLE BIT OF RURAL AMERICA AND WE LOSE A PIECE OF HISTORY.

AND I JUST HAVE TO ASK, WHERE WILL OUR GRANDCHILDREN, SADDLED WITH A MULTI-TRILLION NATIONAL DEBT AND STUCK WITH AN INFRASTRUCTURE IN DISREPAIR, FIND THE RESOURCES TO ENTER FARMING AND REPLACE THE ERODED PRODUCTIVITY OF FARMLAND TRANSPLANTED TO THE THE GULF?

AND THE LIST GOES ON AND ON. DEPLETED GROUND WATER IN THE SOUTHWEST, CONTAMINATED GROUND WATER IN THE NORTHWEST. POLLUTED AND OVER WORKED FISHERIES OFF THE COASTAL RANGES, LAKES STILL DEAD FROM ACID RAIN.

CAN SOMEONE TELL ME WHERE OUR GRANDCHILDREN WILL FIND THE RESOURCES TO CLEAN UP OUR CONTAMINATED GROUND WATER, REPLENISH OUR AQUIFERS, RESTOCK OUR FISHERIES AND REVITALIZE OUR LAKES IF WE DON'T DO SOMETHING ABOUT THE DEFICIT DILEMMA TODAY?

ASIDE FROM THE ADVERSE IMPACT THE AGREEMENT WOULD HAVE ON MANY FEDERAL PROGRAMS, THERE IS ANOTHER REASON WHY I HAVE PROBLEMS SUPPORTING IT.

THE AGREEMENT, AND THE BUDGET RESOLUTION, BOTH FAIL TO ADDRESS THE EXPLOSION IN FEDERAL TAX EXPENDITURES. UNDER CURRENT LAW TAX EXPENDITURES WERE PROJECTED TO RISE FROM $365 BILLION IN FISCAL YEAR 85 TO $471 BILLION IN FISCAL YEAR 88--A $106 BILLION INCREASE! THAT INCREASE IS LARGER THAN THE COMBINED INCREASE IN DEFENSE AND SOCIAL SECURITY OVER THE FY 86-88 PERIOD. YET NEITHER THE BUDGET RESOLUTION, THE AGREEMENT OR THE PRESIDENT'S TAX REFORM PROPOSALS WOULD DO ANYTHING TO HALT THIS HEMORRHAGE OF FEDERAL TAX DOLLARS.

WHEN YOU CONSIDER THE INEQUITIES OF NOT INCLUDING TAX EXPENDITURES IN THE STRUGGLE TO REDUCE THE DEFICIT, YOU GET A BETTER UNDERSTANDING OF WHY THE AGREEMENT FACES TOUGH SLEDDING IN CONGRESS:

THE FEDERAL GOVERNMENT WILL ALLOW YOU TO DEDUCT YOUR $500 FIRST CLASS AIR FARE AS A BUSINESS EXPENSE. UNDER THE BUDGET AGREEMENT, AMTRAK WOULD BE TERMINATED IN ORDER TO SAVE THE $38 PER PASSENGER SUBSIDY.

THE FEDERAL GOVERNMENT WILL ALLOW YOU TO DEDUCT YOUR $30 LUNCHEON EXPENSES AS A BUSINESS EXPENSE. UNDER THE BUDGET AGREEMENT, THE GENEROUS 12 CENT SCHOOL LUNCH SUBSIDY WOULD BE TERMINATED FOR CHILDREN WHOSE FAMILY INCOME EXCEEDS $18,700.

THE FEDERAL GOVERNMENT WILL ALLOW YOU TO DEDUCT THE $300 HOTEL EXPENSES YOU INCURRED OVER THE LAST THREE DAYS AS A BUSINESS EXPENSE. UNDER THE BUDGET AGREEMENT PUBLIC HOUSING OPERATING SUBSIDIES WOULD BE REDUCED BY 20 PERCENT.

AND THERE'S ONE YOU MAY BE FAMILIAR WITH.

THE FEDERAL GOVERNMENT ENCOURAGED ANYONE WITH INCOME TO SHELTER TO BUY FARMS, BARGES AND RAIL HOPPER CARES, DEPRECIATE THE ASSET, OPERATE THEM AT A LOSS AND DEDUCT IT ALL FROM THEIR TAXES WHEN THE AFFECTED INDUSTRY FALLS ON ITS FACE FROM CHRONIC OVERSUPPLY. UNDER THE BUDGET AGREEMENT, IF THE BARGE INDUSTRY WANTS NEW CONSTRUCTION PROJECTS, IT WILL HAVE TO PAY FOR THEM.

AND THAT IS WHY THE BUDGET AGREEMENT PROBABLY WON'T MAKE IT OUT OF THE SENATE. INSTEAD, THE SENATE WILL MOST LIKELY PASS A BUDGET WHICH TREATS EVERYONE THE SAME. EVERYONE, INCLUDING DEFENSE, WILL TAKE A HIT.

NOW, ALL THIS BUDGET DISCUSSION SHOULD LET YOU KNOW WHAT WILL BE THE DOMINANT ISSUE IN THE 99TH CONGRESS. AS THE LAST SIX YEARS HAVE ILLUSTRATED, THE DAYS OF MAKING WATER POLICY ON APPROPRIATION BILLS ARE OVER.

IF, FOR THE FIRST TIME SINCE 1977, THE CONGRESS GETS SERIOUS ABOUT A WATER RESOURCE DEVELOPMENT POLICY, IT WILL BE FORCED TO DO SO WITHIN THE CONSTRAINTS IMPOSED BY THE BUDGET RESOLUTION.

AND I HOPE CONGRESS AND THE ADMINISTRATION DO GET SERIOUS ABOUT A WATER RESOURCE DEVELOPMENT POLICY. IT PAINS ME TO SEE THE DISTRESSED BARGE COMPANIES ON THE UPPER MISSISSIPPI PAYING DIESEL TAXES INTO A TRUST FUND THAT CAN'T BE SPENT UNTIL CONGRESS AUTHORIZES NEW PROJECTS.

IT BOTHERS ME TO KNOW THAT ONE FREAK ACCIDENT AT BONNEVILLE COULD DEPRIVE FARMERS OF ACCESS TO TRADITIONAL WEST COAST EXPORT POINTS. AND IT DISTURBS ME THAT THE INABILITY TO REACH AN AGREEMENT ON INLAND WATERWAYS AND DEEP DRAFT PORTS IS PREVENTING CONGRESS FROM ACTING ON THE RELATIVELY NON-CONTROVERSIAL SUBJECT OF FLOOD CONTROL PROJECTS.

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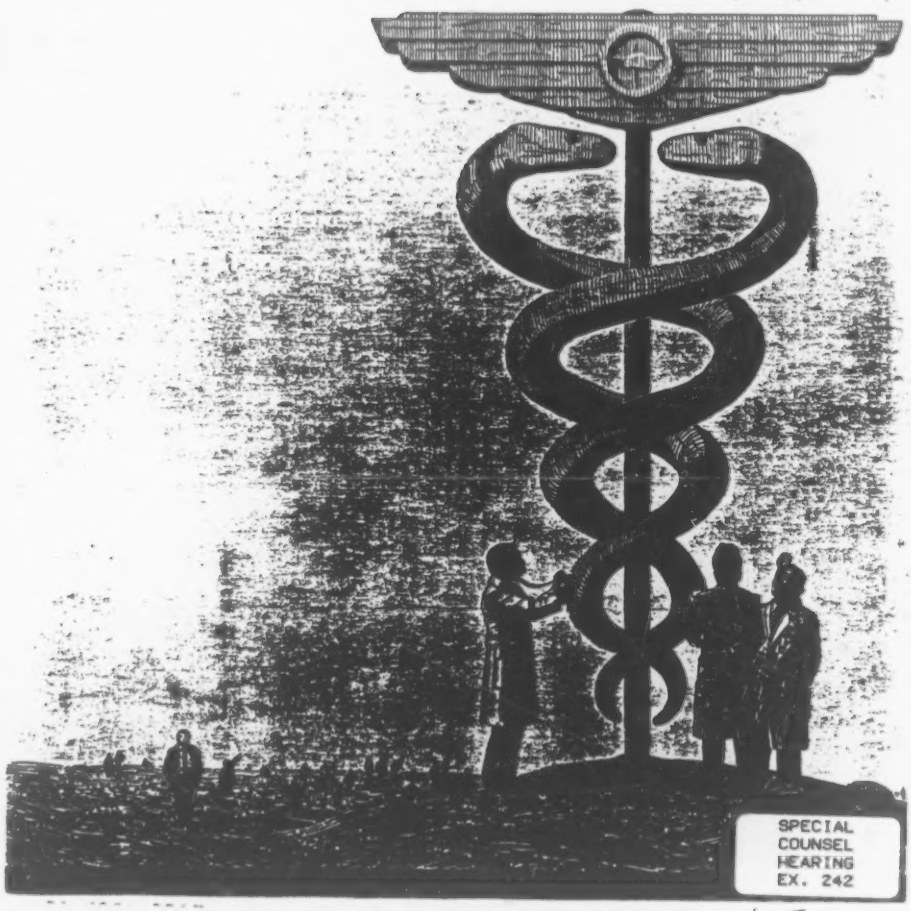
To be honest, we missed the boat last year. I felt the proposal which Jim Abdnor offered to the Continuing Resolution in the waning days of the 98th Congress was a reasonable compromise. While I agreed with my barge operators that the proposal required too much of the new construction expenses to be paid out of the trust fund, I really felt the problem could have been resolved in conference with the House.

GIVEN THE CURRENT BUDGET CLIMATE, I THINK WE WOULD BE FORTUNATE TO REPORT A SIMILAR PROPOSAL OUT OF THE ENVIRONMENT AND PUBLIC WORKS COMMITTEE. BUT, THERE IS NO USE DWELLING OR WHAT WE FAILED TO ACCOMPLISH LAST YEAR. IT'S TIME TO CONCENTRATE ON 1985 AND THE FUTURE. IT'S TIME FOR THE ADMINISTRATION, THE CONGRESS AND THE WATERWAY OPERATORS TO TRY ONCE AGAIN TO RESOLVE THIS SEEMINGLY UNRESOLVABLE ISSUE. AND, AS YOU WALK THE HALLS OF CONGRESS IN SEARCH OF SOMEONE TO GET YOUR POINT ACROSS TO, PAY ME A VISIT.

My door is open, my staff is willing and Minnesota is waiting for a water resource development policy. Let's work together and find one.

Thank you. Have a nice afternoon.

Cost vs. Care: America's Health Care Dilemma



SPECIAL
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EX. 242

"We can well afford to provide equality medical care to all, but we must have a coherent national health policy which will eliminate inefficiences and reduce the cost of health care for our society as a whole."
Califano, former Secretary of Education and Welfare, page 50

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Providence Journal | Brown University | Public Affairs Conference

Cost vs. Care: America's Health Care Dilemma

March 11-13, 1985
Sayles Hall, Brown University

The Schedule

Monday, March 11, 1985

12:00 noon — Welcoming remarks by Howard R. Swearer, President, Brown University

Costs and Causes: An Economist's Viewpoint

Burton A. Weisbrod
Professor of Economics and Director, Center for Health Economics and Law, University of Wisconsin, Madison; Council Member, Institute of Medicine, National Academy of Sciences

Introduction by Michael P. Metcalf, President and Publisher, The *Providence Journal-Bulletin*

4:00 pm — ***Hard Choices: Who Lives, How, and Who Decides?***

Daniel Callahan, Ph.D.
Founder and Director of The Institute of Society, Ethics and the Life Sciences, The Hastings Center

Joanne Lynn, M.D.
Hospice Director; former Assistant Director, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

Introduction by Dan W. Brock, Professor of Philosophy, Brown University

8:00 pm — ***Awarding of Honorary Degree to Jonas Salk, M.D.***

Introduction by Pierre M. Galletti, Vice President, Biology and Medicine, Brown University

Presentation of Candidate for Honorary Degree John Rowe Workman, Professor of Classics, Brown University

2019

Conferring of Honorary Degree
Howard R. Swearer, President, Brown University

Health and Lifestyle

Jonas Salk, M.D.
Founding Director and Distinguished Professor in International Health Sciences, The Salk Institute for Biological Studies

Tuesday, March 12, 1985

12:00 noon ***Access to Care: Where Are the Holes in the Net?***

Gail Wilensky, Ph.D.
Vice President, Domestic Division and Director, Center for Health Affairs, Project HOPE

Sara Rosenbaum, J.D.
Director, Health Division, Children's Defense Fund

John L.S. Holloman, M.D.
Former President, New York City Health and Hospitals Corporation

Introduction by Thomas J. Anton, Director, A. Alfred Taubman Center for Public Policy and American Institutions, Brown University

4:00 pm ***Health Care and the Elderly***

Carl Eisdorfer, Ph.D., M.D.
President, Montefiore Medical Center, Professor of Psychiatry and Neuroscience, Albert Einstein College of Medicine

Introduction by David S. Greer, Dean of Medicine, Brown University

8:00 pm ***The Health Cost of Doing Business***

Joseph A. Califano, Jr.
Attorney, former Secretary, Department of Health, Education and Welfare

Introduction by Frederick M. Bohen, Senior Vice President for Finance and Administration, Brown University

Wednesday, March 13, 1985

12:00 noon ***The Proper Role of Government***

David Durenberger
Republican Senator from Minnesota, Chairman, Health Subcommittee, Senate Finance Committee

Introduction by Robert A. Reichley, Vice President for University Relations, Brown University

4:00 pm ***A Sampling of Alternative Health Providers***

Richard Knox
Medical Writer, *The Boston Globe*

Winfield C. Dunn, D.D.S.
Senior Vice President for Public Affairs, Hospital Corporation of America, former Governor of Tennessee

Daniel C. Burnes, M.D.
President, Managed Care Corporation

Jacob Getson
Vice President of Health Programs Development, Blue Cross Blue Shield of Massachusetts

Introduction by Brian Dickinson, Editorial Page Editor, *The Providence Journal-Bulletin*

8:00 pm ***Cost vs. Care: America's Health Care Dilemma Wrongly Considered***

Part I: The American Critique

Theodore R. Marmor
Professor of Public Management and Political Science, Yale University, policy advisor to the Mondale campaign

Part II: The Canadian Example

Robert Evans
Professor of Economics, University of British Columbia, Vancouver, leading Canadian health economist

Introduction by H. Denman Scott, Director, Rhode Island Department of Health

Introduction

Can this nation afford high-quality health care for everyone? Is good health care a birthright? Who should get heart transplants? Who should have access to kidney dialysis? Who should pay the ever-increasing costs of health care: the individual or the government? How can we increase access to health care, manage the new technologies and ensure quality of life?

These are some of the questions posed by the fifth annual *Providence Journal*-Brown University Public Affairs Conference March 11-13, 1985, on the University campus. The conference brought together nationally respected economists, health care administrators, government representatives, physicians, third-party payers and health policy experts for a three-day exploration of one of the nation's most pressing questions: How healthy is our health care system?

Various speakers suggested that the American health care system is running a low-grade fever and is in danger of additional complications aggravated by cost. A few items from Joanne Lynn:

- Children of the poor are twice as likely to die in their first year as are children of the middle class.
- 10 percent of the population has no physician available and 20 percent can't pay anyway.
- health costs are the most frequent cause of personal bankruptcy.

From Sara Rosenbaum:

- In 1982, one out of 20 pregnant women and one out of 10 pregnant black women received no prenatal care until the third trimester; one out of nine women under age 20 received no care at all.
- One out of three black children has never seen a dentist.
- In 1982, one million families were refused care because they couldn't pay for it.

From Theodore Marmor:

- One fifth of American children are not immunized against polio and only one half are immunized against preventable childhood diseases.
- 25 percent of Medicare's $60-million budget is spent for care in the last month of life.
- 25-30 million Americans are not covered by health insurance.

Access and cost — without doubt the two greatest health care problems facing Americans today and in the years ahead. The various conference speakers addressed these complex issues with insight and considerable hope. As one speaker put it, the U.S. is not locked into a phony technological determinism. There are options.

In the speeches that follow, the reader will learn how Massachusetts has lowered health costs with the introduction of health maintenance organizations (HMOs); how and why the traditional fee-for-service system contributes to higher costs and inefficiencies; what Americans can do to avoid the worst aspects of health care rationing. The reader will learn why America must have a national health policy and, at the same time, why the government is ill-equipped to tackle the task. Most of all, the reader will experience the breadth of the debate that must be conducted for real solutions to emerge to these critical issues.

The conference concluded with a presentation by a Canadian health economist, Robert Evans, who argued that Canada has shown that quality health care is not necessarily a choice of "your money or your life." Taking issue with some of the speakers, Evans stated that regulation — of physician incomes, quantity of equipment for hospitals, services available — *not* competition has enabled Canada to provide health care to all at a reasonable cost.

The conference demonstrated that the questions are perplexing, the solutions elusive, yet some common ground was found. Callahan said we all can agree on equal access for all, that no group should bear an unfair burden, and that all should participate in making the decisions if rationing is required. Salk called for an increase in creative wisdom and wise compassion, an evolution in our way of thinking. And Eisdorfer, referring to reassessing long-term care for the elderly, urged that we be humane to all of society, including, he noted, our future selves.

Costs and Causes: An Economist's Viewpoint

Burton Weisbrod

Professor of Economics and Director, Center for Health Economics and Law, University of Wisconsin, Madison; Council Member, Institute of Medicine, National Academy of Sciences

Burton A. Weisbrod, with degrees in management and economics, has taught at the University of Wisconsin since 1964. Before that he served as Senior Staff member of the Council of Economics Advisors (1963-64) and taught at Northwestern University, Carleton College, and Washington University. He has been a visiting professor or scholar at Branders, Yale, the Kennedy School of Government at Harvard, and Princeton.

A Member of the Governing Council of the Institute of Medicine and former President of the Midwest Economics Association, he is also a Senior Research Fellow, Brookdale Institute in Jerusalem, and National Fellow, Educational Finance and Productivity Center, University of Chicago.

He has written and published widely on topics generally focusing on the economics of health and education; health policy, and benefit cost analysis.

Fifty years ago the United States devoted only about 3 percent of its total output to health. Twenty-five years ago, this had increased to 6 percent. Today, it is 11 percent, amounting to some $2,000 annually per person. What has happened?

Whatever has happened, it has not been limited to the United States. Health care expenditures throughout the world — particularly in the economically developed world — have soared. The massive share of national product devoted to health in the United States is similarly large in Switzerland, Sweden and Italy; it is considerably lower, though, in the United Kingdom.

Why has the growth come to be seen as a problem? When output of most other commodities rises, it is not seen as a bad sign. What is different about health care? This is the starting point for an understanding of our health care dilemma.

There are four senses in which health care and ordinary commodities differ. First, health care involves life itself — at least, sometimes. Second, consumers are not well-informed about medical care. What kind of care to seek, from whom, and how to judge its effectiveness. A recent newspaper cartoon illustrated the problem that a patient has in determining the quality of medical care. A nurse is standing over the bed-ridden patient, offering a pill and saying, "Take this. It will help the nurses to relax." We laugh because we recognize that the patient does not really know when a sedative is given with the patient's interest being paramount, and when for other reasons.

A third sense in which health care differs from most commodities is its reliance on governmental and private nonprofit sellers. Private enterprise is not nearly so prominent in health care as it is in the economy generally. Some 25 percent of all nursing home beds are in governmental or nonprofit facilities and about 90 percent of all short-term hospital beds are in such non-market facilities. My view is that the great reliance on non-market organizations reflects the consumer-information problem. Consumers prefer to deal with organizations that they believe will not take advantage of their lack of information.

Health care also differs from most other commodities in a fourth way — the way in which it is financed. Health care insurance is subsidized heavily, either through governmental programs such as Medicare

and Medicaid, or through private insurance that receives special, non-taxable, treatment in the personal income tax law. All subsidies, including these, encourage utilization. Indeed, that is normally the intent.

These differences between health care and ordinary commodities have enormous consequences. A sensible policy of cost containment must recognize them. But in health care, as elsewhere, critical decisions simply will not wait until the academic research community has resolved these matters.

It is strange that despite the obvious fact that consumers are frequently poorly informed about quality of health care, and that little is known about the outcome of competition among for-profit, governmental, and private nonprofit organizations, current public policy efforts to contain costs are looking to increased competition as a solution.

Competition in the health care market is indeed heating up. Hospitals are actually advertising. Traditional fee-for-service providers — physicians and hospitals — are increasingly finding competition from new forms of provider organizations. Foremost among these is the HMO (Health Maintenance Organization), in which a group of physicians contracts with patients to provide a wide range of health services — including physicians' care and hospital services — for a fixed annual fee.

HMOs are an interesting invention. Most consumers are accustomed to dealing with both a health insurance company and health care providers — principally physicians and hospitals. Dealing with an HMO is different. In effect, the HMO is a merger of an insurer and a provider of health care. It is an insurance company in the sense that it collects annual premiums from subscribers and then absorbs the risk that this premium income will cover its expenditures. It is also a provider of health services — directly by its own physicians, and indirectly by hospitals with which it contracts.

The belief that HMOs can succeed in containing costs is based partly on faith in competition — assuming that a number of HMOs grow up in a given area and compete with each other and with private physicians — and partly on the faith that the merger of insurers and health care providers is desirable. The theory is that HMOs, as *insurers* who have collected a fixed sum of money per person for the year, have the incentive to see to it that they, as *providers*, deliver levels and quality of health care that stay within the budget. If they overspend, they lose money — which means that they must cut salaries, including those of the physicians who generally own the HMO, hospitalize patients less, prescribe fewer or less costly medications, or find other ways to reduce the financial outflow.

From the cost-containment perspective, the key feature of the HMO is that it improves its financial position by spending less, not more, on health care services. (This assumes, of course, that consumers do not detect any deterioration of quality as the HMO cuts its expenditures.)

By contrast, under the traditional fee-for-service system of payment, physicians and hospitals can improve their financial position only by providing more services. This has the effect of driving up health care expenditures.

Is more consumer choice desirable? The answer may seem to be a self-evident "yes." To economists, there are few propositions more broadly accepted than the one that says more options are better. An individual cannot be made worse off, it would seem, by having a wider range of alternatives. If the expanded options are not wanted, they can always be disregarded. If consumers can choose between their traditional fee-for-service arrangement and an array of HMOs, would society not be better off?

Not necessarily! It is true that more options are desirable *if* consumers are sufficiently well-informed to make wise choices. But knowing "good health care" is difficult for most consumers.

The debate over the appropriate role for profit-making organizations in health care, for example, is now raging. While the search for understanding proceeds, and despite the many conflicting claims, rapid change is now occurring in the economic organization of the health care industry. There is, for example, the highly-publicized program of artificial heart implantation by the for-profit Humana Heart Institute. To some this represents a model of the leadership and innovativeness claimed for the private enterprise economy; to others it represents an ill-timed, scientifically unjustified effort to grab headlines and inject considerations of profit where it does not belong.

Now I want to return to the question I posed earlier. What has caused the enormous increase in medical care expenditures? There are two principal answers. One is technological change — the explosion of knowledge. The other is insurance — the way we pay for health care.

Technological Change. As recently as 50 years ago, the physician was largely a diagnostician, able to identify particular illnesses and even to predict the likely outcome, but then do little more than provide guidance to the patient and his family while the illness ran its full, natural course.

> The key feature of the HMO is that it improves its financial position by spending less, not more, on health care services.

Technological change — health care research and development — has changed that. Some of the new technologies have led to reductions in health care expenditures. This is true of a number of vaccines, such as the one for polio, which permitted the disappearance of the costly iron-lung technology, and for rubella (German measles), which has drastically cut the occurrence of mental retardation among babies whose mothers would have contracted rubella during pregnancy.

Psychotropic drugs for treating the mentally ill have also brought spectacular expenditure-cutting results. In large part because of these new drugs, mental hospitals today have only one-fourth as many patients as they did 30 years ago.

If only it were true that technological change could be counted on to solve the cost-containment problem. Unfortunately, advances in health care technology in recent decades have often achieved the op-

posite — they have increased health care costs. Neonatal intensive care, for example, has increased life expectancy of infants with very low birth weight, and while many of the additional survivors are normal, an important fraction, particularly in the lowest birth-weight group, experiences high expenditures for medical care over their lifetime. The survival rate for victims of spinal cord injuries, to cite another example, has improved tremendously since early in the century, but this is another group with continuing high expenditures.

One thoughtful analyst has focused on such failures of success. The conquest of infectious diseases such as pneumonia has increased life expectancies most dramatically for those with severe chronic conditions, who would otherwise have died but now remain alive and incur large health care costs. The prevalence of Down's syndrome and senile brain disease are evidence of this. The effects of those diseases on health care costs is substantial. There are both costs and benefits of the great technological advances in health care.

So, why are health care expenditures rising so fast? Technological advances are a major factor — particularly advances in surgical techniques. Consider the coronary artery bypass operation. Its widespread use is under increasing attack, especially from cost-conscious circles, for it now consumes more of our medical dollar that any other treatment or procedure.

A decade ago there were some 60,000 such operations performed annually. Now, there are 200,000. At a cost of about $20,000 each, this one surgical procedure costs $4 billion per year. Its benefits in the form of reduced risk of heart attack and increased longevity are doubtful. And while the evidence is substantial that it reduces chest pain, there is growing question of whether that is more than a placebo effect — people believe the operation will reduce pain, and this belief, some claim, is what brings about the effect. The final evidence is not yet in, but we might be wise to seek another, less costly placebo.

Q Would you care to speculate concerning the amount of legal costs that are going to be generated by the Diagnosis Related Group system. I already know of two legal cases where patients were discharged under controversial conditions because their allocations of funds had been used up, and they're now in the courts. To what extent are we going to be spending our savings in the courtroom?

A I tried to touch on that by referring to the subtle ways that quality would be cut as a direct result of the DRG system. One might ask the following question. Since a hospital is paid a particular price depending on the diagnosis of the problem of a given patient, and that the payment they get does not in any way depend on what they're providing, one might ask what is it that prevents a hospital from reducing expenditures down to zero? Well, there are many answers, one of which is the medical malpractice litigation route, not that that's the only one, but it is one of the answers.

One of the ways that anybody — physicians, hospitals, non-health care providers — is kept honest under the system is through the threat of litigation. We are an increasingly litigious society. Medical malpractice claims in general have been rising a great deal over the last 10 or 15 years. I think it is clear that the DRG system, by virtue of its incentive to chisel away at the margin of cost, is likely to lead to some increase. I would not expect major changes, but I would expect some increase in the number of hospital malpractice suits. I think hospitals are aware of this.

They're also trying, in a variety of ways, to become a bigger part of the community, to make people think kindly of them. Attitudes are extremely important. I looked at some interesting data a year or two back, on the amount of malpractice litigation by state. There is enormous variation across the states, and in ways that I think have little or nothing to do with the objective reality of malpractice.

I wonder if you could guess which states have the most malpractice litigation per thousand population, and which the least. States like New York are way up there at the top. Wisconsin happened to be way down at the bottom. I don't think that had anything to do with physicians being any better in Wisconsin than in New York. I think it has a lot to do with relationships between patients and physicians. Hospitals under this new kind of pressure are increasingly trying to win friends and influence people in the community.

The last few years have witnessed a series of other major technological breakthroughs which now permit production and implantation of artificial joints and organs and transplantation of organs. These new technologies are placing historically unprecedented strains on our health care system. The human body is rapidly becoming analogous to an automobile. I have here a price list of replacement parts, not for the car, but for the body.

Leg or arm	$1,000-3,000
Elbow	$1,200
Ankle	$700
Blood vessel	$300
Toe joint	$99
Ear	$10,000
Heart	$50,000-80,000
Heart valve	$2,000

Yes, these parts are available in small, medium, large and extra-large. Installation, however, is extra!

Some other replacement parts are available, but only in "used" form — kidneys, livers, lungs, pancreases and intestines. With varying degrees of success these can now be transplanted from one person to another. Liver transplantation illustrates well the interplay of technological change, health insurance, health care costs, and hard ethical choices.

The liver transplant is possible today only because of a recent technological development — the drug, cyclosporine. Cyclosporine permits the transplant to work by suppressing the body's immune-system reaction to the transplanted organ but, unlike earlier immunosuppressant drugs, cyclosporine does not stop the body from fighting off infections. It is a medical breakthrough. The good news is that people with liver and kidney failure can now be kept alive.

The bad news is that a single liver transplantation costs about $200,000, and another $20,000 per year thereafter. With a potential demand of 5,000 or more patients per year, a total cost of $1 billion annually is involved.

Insurance. The increasingly costly results of technological change brings me to the second reason for the soaring expenditures on health care—insurance. Few

people can afford a $200,000 surgical bill for a liver transplant. Unless insurance covers liver and other organ transplants, patients will die.

The government-supported social-insurance program to finance dialysis for victims of kidney disease is already costing more than $2 billion per year, and there is growing concern that as costly new technological advances occur, the enormous individual price tags will put relentless pressure on government to expand health insurance coverage to make the new life-saving technologies available to all. The State of Massachusetts has already mandated that all health insurers must include liver transplants in their coverage. Most states, however, and most health insurers, continue to term the liver transplant "experimental," and experimental techniques are not covered by Medicare, Medicaid or most private insurers. Given the considerable success with the liver transplant, however, I see its exclusion from insurance coverage as nothing more than a way to hold down costs. This is a side effect of the cost-containment emphasis. We exclude patients from the use of a new but costly technology simply by calling it experimental.

> Doctors and hospitals are re-using items that were made and labeled by the manufacturers for one-time-use only.

Insurance has had another effect on health care expenditures — less visible but in the long run more important. Insurance has changed the pace and the direction of technological change. That is, insurance and technological change are not two separate forces affecting health care expenditures; they are interdependent. Insurance has increased the profitability of new high-cost devices and techniques, and consequently has spurred their development. A health insurance system that pays the cost of any health care that a physician certifies to be useful whatever its cost sends out a clear signal to the research and development community: Improve quality, regardless of cost; do not worry about cost containment.

The signal was successful, but we are now recognizing that it was too successful. Improved quality of care is good, but not regardless of cost. Since 1955, a seven-fold increase in the amount of real resources devoted to health is simply too much.

It is no coincidence that technological change in health care has turned out to be expenditure-increasing far more often than expenditure-decreasing. The health insurance system we adopted and expanded in the post-war era could hardly have been better designed to encourage the search for higher quality health care — and quality invariably implies higher cost.

For the past 18 months we have been in the process of drastically changing the signals that the health insurance system sends to the research and development community. I am talking about the new "prospective payment" system for paying hospitals — the DRG (Diagnosis Related Group) system. Under this system of insurance payment (which was promulgated by Medicare but is being extended to other insurance arrangements), a single price is paid to a hospital for treating a patient with each of 468 designated medical problems. What is revolutionary about this system is that the payment received by the hospital for treating a particular patient depends only on the nature of the patient's medical problem, not on how the patient is treated.

Thus, hospitals are now receiving an entirely new signal: Cut expenditures — even if quality suffers a little. I forecast this signal will also work; costs will be cut, but quality will also suffer. It is not that doctors and hospital administrators are uncaring of their patients, but they cannot disregard the pressures and incentives they confront. The changes will be subtle. Up to some point, reductions of cost will not reduce quality of medical care at all, as with the substitution of hamburger for steak on the hospital's dinner menu. Up to some point the quality of medical care will be reduced, but to such a small degree that it is undetected by the various internal and external regulatory mechanisms. Up to some point the decrease in quality will be detected but will come to be accepted as "small" and worth the cost saving. And to some extent the reductions in quality will be detected and even punished, but they will continue nonetheless, as with all regulatory violations.

One example will illustrate how the pressure to cut expenditures can lead to seemingly small and, to the patient, even unrecognized, but possibly significant decreases in the quality of care. Until the late 1940s, hospitals and doctors used most medical devices over and over. Tubing, syringes, needles, etc. were made to be used, then sterilized, and used again. Then came the disposables; more convenient and safer, they were quickly adopted by a health care system in which all

Q Are there incentives in the DRG system to choose the most costly diagnosis when there's any flexibility in deciding what's wrong with a patient?

A That seems pretty clearly to be the case. In case others aren't entirely clear on the issue, what's involved is this. When a patient comes into a hospital, some determination of what the problem is, what the diagnosis is, has to made to determine which of these 468 prices the hospital receives.

Sometimes it's perfectly clear and unambiguous. A person comes in with a broken leg, the diagnosis is broken leg. Very often, however, people come in with multiple problems, and there is then an incentive for hospitals to look for that diagnosis which would give them the most money. That has implications for the budgetary costs of health care. It has no particular implications, I believe, for the quality of care that is provided. My judgement would be that hospitals would not change what they are doing, in terms of the kind of care they're providing, but they would change what they call the diagnosis, in order to influence the amount of money they get. In the past, it didn't make any difference to a hospital what they said the problem was. All that mattered, in terms of their income, was what procedures did they utilize.

"reasonable" costs were covered by insurers. Today, as a direct result of pressures to cut costs, sterilization and re-use is increasing. What is most notable, though, is that doctors and hospitals are re-using items that were made and labeled by the manufacturers for one-time-use only.

Even filters for kidney dialysis machines are being reprocessed and reused, even though they too are supposedly designed only for a single use. The cost savings are certain; what is a subject of debate is the extent of health risks. Faced by cost-side pressures, however, health care providers will increasingly opt for lower cost, even when there is some uncertainty about safety and efficacy.

Society would be hiding its head in the sand to believe that quality of care will not suffer from these changes. The DRG and other prospective payment insurance mechanisms, including HMOs, have effects going far beyond the efficiency and utilization of existing health technology. They will sharply redirect the course of research and development, and in a predictable direction. Specifically, development of new surgical techniques will diminish in relative importance. Since surgery is necessarily "custom" production — not taking advantage of mass production economies — it is bound to be costly and hence less attractive in a cost-containment environment. Pharmaceuticals will look more attractive, especially those that prevent the onset of costly treatments — for example, vaccines — and those that substitute for surgery — for example, beta-blockers, which can substitute for coronary bypass surgery, and cimetidine, which reduces the need for ulcer surgery.

The central point I have made is that the extraordinary cost of many of the latest technological breakthroughs is not an accident; it is the direct result of the interplay of technological change and the health insurance system. Now come the hard choices. There are two. One, which has come to be recognized, is how far we as a society are willing to go to make the best medical technology available to everyone. The other has been largely overlooked, but in the long run it is more important. How far are we willing to go to develop new medical techniques and devices that can extend life and improve its quality if they are likely to be very costly?

We should be careful in our thinking. What does it mean to say that a new medical technology is "very costly?" Relative to what? As our real incomes grow, we can afford to spend more on health care and also on other things. As we rush headlong for the containment of costs, we should remember that there are also *benefits* from improved health. The search for a "balance" of the two is our true target.

Sometimes the balancing is simple. For many of us it is not hard to decide in favor of giving a liver transplant — even one costing $200,000 — to an infant born with congenital liver disease. It may not be hard to decide in favor of even a thousand of these per year, at a cost of $200 million.

But what about the thousands of adults who have liver failure each year because of alcoholism? Are they deserving of such costly care?

And what should we do about the small segment of the population that is incurring the bulk of health care costs? Let me pose a challenging question. Should there be a limit on the total amount of health care resources that is spent on any one person? Or should there be no limit?

> Should there be a limit on the total amount of health care resources that is spent on any one person?

No society is likely to face such a question squarely. The British have answered it, in effect, by decisions such as the one to refuse life-saving, but costly, kidney dialysis to persons over age 55 developing kidney disease. They have also engaged in a deliberate policy to hold down drastically the number of CT scanners. Not only are these devices — which were first developed in the United Kingdom — very costly (over $1 million each), but they diagnose problems that are often very costly to treat. The more widely available is such equipment the greater the ensuing health expenditures are likely to be.

And as we recall the "replacement parts" information I presented earlier, we should ponder the question of whether there should be any limit at all on the number of parts that an individual may have replaced. Only last week a patient in Arizona received two heart transplants and an artificial heart implant within days. The cost was staggering. Should all three operations — and additional ones, if medically required — be covered by health insurance? By governmental programs?

I want to leave you with three "lessons" which summarize what I have said.

- Lesson 1: *In health care, as elsewhere, the economist's maxim holds. There is no "free lunch."* I wish I could agree with one distinguished economist who recently wrote, "... it is possible to cut cost without cutting the quality of care." There is no way to cut expenditures more than trivially without diminishing the quality of health care for at least some people, and without affecting incentives for development of better technology.
- Lesson 2: *Cost containment is an appealing but dangerous social goal.* We do need to right the balance between holding down expenditures and increasing the benefits from those expenditures. We do need to pay more attention to costs, but let us be careful to avoid going too far. We should not lose sight of the need to balance our proper concerns about costs with the equally proper concerns about benefits. There is no "solution" to the problem such that when we find it we can relax: not HMOs, not DRGs, not anything.
- Lesson 3: *In health care, as in other public policy arenas, if you or I think we have a solution, it's only because we do not understand the problem.*

As we try to wrestle with these complex issues, we see that they entail a number of elements: economic, political, philosophic and medical. Fortunately, people representing each of these are addressing this conference.

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Hard Choices — I: Who Lives, How, And Who Decides

Daniel Callahan, Ph.D.

Co-founder and Director of the Institute of Society, Ethics and the Life Sciences, The Hastings Center

Dr. Callahan was the co-founder of The Hastings Center (Institute of Society, Ethics and the Life Scineces) and has been Director of the Center since its beginning in 1969. Prior to that Dr. Callahan was Staff Associate at The Population Council (1969-70) and Executive Editor of Commonweal magazine (1961-68). Dr. Callahan has also been a visiting professor at Bown University, the University of Pennsylvania, Temple University and Union Theological Seminary.

Dr. Callahan is the author or editor of numerous books and articles. Among his most recent books are "The Tyranny of Survival," a study of technology, "Abortion: Law, Choice and Morality", and "Ethics and Population Limitation."

He is an elected member of the Institute of Medicine, National Academy of Sciences, and an elected Fellow of the American Association for the Advancement of Science.

Since the time of Hippocrates, a concern for morality has always been a part of medical practice. The relative centrality of that concern, however, has waxed and waned over the centuries, often in response to different public perceptions of medicine, or because of important technological or other developments. The past two decades have been remarkable in that respect. It is difficult to discover a historical period when the interest has been so intense, widespread and often controversial.

There are a variety of possible reasons to account for the new interest. The development of new technologies, the changing nature of patient populations, reassessments of the doctor-patient relationship, and significant biomedical advances are all part of the story. The care of dying patients, mass screening for genetic disease, the use of drugs to modify behavior, prenatal diagnosis, organ transplantation, and the widespread use of human subjects for research are among the array of issues that have created new moral problems in decision making — at the personal, the institutional, and the state or national level.

The source of those problems is not medicine's weaknesses or failures, but its triumphs. The most obvious change in medicine since the turn of the 20th century is that it is enormously more successful and effective than was earlier the case. Medicine now has genuine power. That power has led to a massive investment of resources in research and delivery, has exceedingly heightened expectations about the benefits of health care, and has fos-

tered close relationships between medicine, government and society.

These developments have generated some fundamental questions about the enterprise itself. The turning off of a respirator (which of course did not exist a century ago) provides the simplest and most common example. If it was traditionally considered a fundamental part of the work of the physician to forestall death as far as possible, some basic questions about the nature of what it is to be a physician come into play when a conscious decision must be made to turn off a machine, and thus in one sense to cause a person's death. The neonatologist can save many of the lives of low-birth-weight babies, that would have been considered hopeless in the past. But frequently he or she is faced with the question of whether the effort is morally worth it, when the results may be a life of severe and crippling disease or disability.

In short, there are enormous, but still limited, powers and that is the kind of circumstance that always produces moral dilemmas. There is much that medicine can do to forestall death and relieve pain and suffering, but much that it still cannot do and may never be able to do. It is hardly any wonder in that circumstance — which has now become endemic to medicine — that moral problems arise, and that even more fundamental questions arise about the nature of health and illness, about the appropriate goals of medical and health care, and about the relative rights and obligations of health care providers and the patients. One cannot grapple with any of the moral problems without going back to the nature and goals of medicine itself.

It is important to distinguish between two general classes of problems. The first class, much more familiar in the history of medicine, is that of trying to determine the proper course of action for an individual with decision-making power. What ought the individual doctor do when faced with a dying patient? What ought the transplant surgeon do when a decision has to be made about a risky procedure? What ought the cancer specialist do when a choice must be made between the extension of a life that will be accompanied by suffering, or of not beginning therapy at all, knowing that life will thereby be shortened? Those individual questions can be extraordinarily hard, and even if patients and their families are brought in on the decisions, the issues will often remain difficult.

The second class of problems — those concerned with policy — present us with a very different situation and are those that will concern me here. With most important policy issues, the decisions taken will affect whole classes of patients or potential patients, not just an individual patient. A decision may affect the lives of thousands or millions. In addition, with most large policy decisions, there is rarely an individual decision-maker as such. There are political administrations, or legislatures, or state or district administrative bodies. No one person alone is faced with the decision.

On the contrary, as many policy analysts are fond of pointing out, it is often difficult to find out just how decisions actually got made, or who was responsible for them. Yet, what could be of greater importance to the health of a nation than the policy "decision" to invest a certain amount of the gross national product in biomedical research and health care delivery? At the same time, as we now know, that investment has spawned not only better health but a heavy and constantly escalating economic burden.

While it is by no means the case that expensive new technologies are solely to be blamed for the rapid rise in health care costs, they play a significant and troubling part. We are all aware of the high cost of dialysis, neonatal intensive care units, coronary by-pass surgery, and so on. The prospect of even better techniques of organ transplantation, and of an effective artificial heart (to pick only two examples) presents a picture both exhilarating and depressing. It is exhilarating because we know, with further biomedical research and improved technology, many additional lives can be saved in the future. It is depressing because we also know the likelihood that the number of countries which can really afford to move ahead at full speed is very slight. We will know what could be done, and what the benefits will be — but often simply will not be able to do it. Some hard moral choices will thus have to be made.

We have also now moved into an era of chronic disease, posing no less difficult but even more pervasive problems. That fact raises social and health care problems of the first magnitude, particularly as the relative proportion of the elderly increases in our societies. In many cases, the issue is one of providing better health care, but it is no less an issue of providing a wide range of non-medical social services as well, which together with available health-care will make the difference between whether a person lives a reasonably passable life in the presence of chronic disease and disability, or one marked by misery and hopeless decline.

A decision may affect the lives of thousands or millions.

While sharp and explicit conflicts between the younger and older generations for resources have not yet quite appeared, it is hard to see how they can be avoided for much longer. Fewer and fewer young people will be called upon to provide the money to support more and more elderly people. Trying to think through the problem of justice in that conflict — who owes what to whom — raises as difficult a set of ethical issues as one can imagine.

We ought to know, moreover, that the cost of *significantly* improving health — that is, radically changing mortality and morbidity outcomes for the population as a whole — has become astronomical. How, then, are we to determine when enough is enough, and to decide when further investments in health care delivery are simply not worth the price? We know there are dozens, perhaps hundreds, of ways to improve health and there are no fewer number of promising leads in basic biomedical research. But it has become reasonably evident that there are increasingly few inexpensive ways to achieve the further possible gains. Even very large investments of money are not likely to make

a great deal of difference in gross morbidity and mortality statistics. The general returns are increasingly marginal.

At the same time, all of us know of individually tragic cases where a new drug or a better therapy or some other improvements would have saved individual lives, or at least made those lives considerably more tolerable. We also know that many of the poor, and certainly many of the elderly, still do not receive decent medical care, and that their lot could be improved by the investment of more money.

Nonetheless, aggregating all groups into one large health pool, it remains true that the amount of money it would take to significantly improve the overall health of citizens in developed countries would be staggering — and simply out of the question.

Are we then to say that only the general data counts, resulting in aggregate welfare in which individuals must be sacrificed? Or should we persist in our belief that we must focus on the welfare of the individual — a concept which is central to the traditional ethic of medicine? If the latter is the case, does it then follow that we are obliged to spend all the money necessary to save an individual life?

Those questions are much too large and much too difficult to be answered in any simple, straightforward way. At the least, we must recognize that there are many other aspects of human life than health that need money and improvement as well — housing, transportation, education, and so on. Because there are reasonable needs and demands in those areas, we are then forced not only to balance off many needs in the health care system, but also to balance health needs against other social needs.

One might say, plausibly enough, that health is so fundamental that it must take priority — that without good health, it is difficult for people to profit from the other goods and values in the society. But that is too simple an answer. There is solid evidence to indicate that such basics as good nutrition, housing, higher education levels, and the like directly correlate with higher levels of health, quite independently of the availability of medical care.

If my general analysis is correct, how are we to get at the problem of making decisions about investments in health care resources in the face of the increasingly marginal returns from those investments? I have come to the doleful conclusion that it is the kind of problem that may not profit all that much from a direct approach. A pure cost-benefit approach, for example, is not likely to be very helpful. Instead, we are going to be forced to ask some deep and profound questions which go beyond the delivery of health care. What ought people reasonably expect from life? What ought they to expect in the way of support for their health needs from their neighbors and fellow citizens? How ought we to understand the meaning of concepts such as "health" and "illness"?

Since the question of allocation of resources is inevitably going to be a persistent one in the decades ahead, I do not believe we can make any substantial progress unless we grapple with those questions and better understand some fundamental traits of Western society, in particular the way it understands progress, justice, and the meaning of health.

Western societies long ago rejected the concept of fatalism — that is, the belief that the way things are is the way they ought to be. If our belief in progress has been somewhat dampened by experiencing the unforeseen side effects of many of our technologies, it still lives on and presses us to do even better than we have done in the past. Nonetheless, one does not need to be a fatalist to recognize that there is simply no way now or in the foreseeable future that all possibilities for progress can be pursued and achieved. We will have to learn to live with limits; that is, learn to live without the lure of endless progress.

> The cost of significantly improving health . . . has become astronomical. We will have to learn to live with limits.

The fundamental ethical issue is how we ought to go about making those decisions that will attempt to balance further, and probably infinite, possibilities in better health against the need to establish economic limits on health care expenditures and investment in basic research.

In part, that is a basic problem of justice. We can, as many have tried to do, seek to determine some minimal health needs and give priority to those needs. But that is easier to say than do. The health needs of a child, who successfully survives a neonatal intensive care unit only to face a life of chronic impairments and disability are much greater than the needs of the normal, healthy child. Some people, patently enough, require the expenditure of much more time and money than others to achieve even a minimal standard of health.

Yet, the cost of helping those whose health care needs are exceedingly expensive can result in the deprivation of those in better health. We can turn, in situations of that sort, to a utilitarian calculus, suggesting that such issues be resolved in terms of "the greatest good for the greatest number." But the problem with that formula is that it is inevitably unjust toward those who have the misfortune to be born with, or to contract, the relatively rare diseases. At the other extreme, the language of untrammeled individual rights seems no more helpful; if there are to be rights, they must be constrained.

A second major ethical issue is one I would call the problem of rationality. It is very tempting to seek optimal theoretical solutions to questions of justice. Such solutions would, for instance, seek to find ways to rank all human beings in terms of their value to society. It would provide means to make difficult decisions by giving a specific weight to the value of different human lives. Those with a higher value would get the resources.

The trouble with that kind of optimal rationality is that there are never likely to be any just formulas that will work in such a simple fashion. Moreover, I personally shudder at the notion of a society that would have everything absolutely parceled

out in an exceedingly tidy, neat fashion. One might, hypothetically, propose as a "rational" solution that all people over the age of, say, 65 or 70 be systematically deprived of needed health care for the benefit of younger generations, or that no child be accepted into a neonatal intensive care unit unless the prospects for a healthy, economically productive, life were highly certain. Who, in such a society, would look forward to aging with any sense of security, or look forward to childbearing with any great pleasure?

> No one class of human beings is inherently less worthy of health care than another class.

The third ethical issue is that of determining appropriate political and other processes for making what will amount to rationing decisions. If it is not likely that perfect theoretical solutions can be achieved, we are then forced back to considering what processes of decision making are most likely to be acceptable and do the least moral harm. One thing that seems apparent is that no health care system in the Western developed countries has a perfectly clean, decisive decision-making process — at least, concerning the broadest categories of research and health care delivery. By that I mean that there is no clear political process that makes a definitive judgement that heart disease is comparatively more important than kidney disease, or that rehabilitation medicine is comparatively more important then preventive medicine. Of course, one can read the data on the way in which our countries actually allocate health resources and attempt to extrapolate from that data what the relative priorities seem to be. But it would take an incredible naivete to believe that the relative weight actually given to different health needs was achieved by any formal, wholly rational process.

I am only saying that rationing and allocation decisions are made all the time, but the procedures by which they are made are visible only in part. One method of rationing is simply to create queues for some services, that is, the services are available but one has to wait a long time to get them. Another method is to change "medical indications" as resources change. Once dialysis was made available to all in the United States by an act of Congress, there was a comparatively rapid change in the thinking of physicians as to when dialysis was "medically indicated." While the notion of a "medical indication" has the ring of science and precision about it, it is in fact partially a function of available resources and of attitudes toward different classes of patients and toward different individual patients.

Still another method of rationing and allocation is simply to provide all regions and districts with a certain amount of money, and leave it up to them to make the decisions at the local level by whatever means they find suitable. On paper, that sounds reasonable enough but we certainly know that different regions often make very different decisions, often for no rationally ascertainable reason.

I have presented a somewhat gloomy picture here. I have suggested that an acceptable theoretical solution to the problem of justice and health care delivery will be exceedingly hard, if not impossible, to find. I have also suggested that we are not likely to find optimal rational solutions, and that it might be dangerous to seek some kind of pure rationality. I have also noted that many of the actual rationing devices now in use — often tacit rather than explicit — are anything but rational and just.

Is there, then, no reason to hope for a satisfactory outcome in the allocation of resources in the decades ahead? I am not all that gloomy. If we expect perfection, we won't get it. But we may be able to settle for something less.

In many areas of ethics, it is far more difficult to achieve an exact agreement on the goods we are seeking than it is to gain agreement on some of the evils we need to avoid. Given our constantly expanding biomedical knowledge, it will become harder to formulate the nature of minimal basic health needs, at one extreme, or of optimal health and well-being at the other. The frontiers in both respects will continue to expand, making definitions of "health" and "illness" elusive and transitory.

For all that, I think that we can specify some evils to be avoided, and take steps to assure that some of the worst possibilities are avoided. We could agree, I believe, that no one class of human beings is inherently less worthy of health care than another class. We could agree at whatever the process of decision making, there be a general public participation in that process, and that whatever decision is reached at one time always be open to being overturned or readjusted at another time.

We can agree that all human beings ought to have equal access to available health care to meet their minimal health needs. We can agree that all societies, whatever their economic circumstances, never cease doing whatever they can to improve their biomedical research and their health care delivery system.

We can agree that, whatever the method of allocating resources, it will be unacceptable if it *appears* to any group in society that they bear an unfair burden. I stress the word "appears" simply because, in matters of health, it is not just the actual state of affairs that counts, but also the way people psychologically perceive that state. A persistent anxiety about one's health, or about the care that one will be given in the future, can be crippling in itself. There is no way we can easily reduce people's anxiety about their mortality and eventual death, but there are many ways we can work to reduce their anxiety about how their society will treat them when that inevitable time arrives.

Hard Choices — II: Who Lives, How, And Who Decides

Joanne Lynn, M.D.

Hospice Director; former Assistant Director for Medical Studies, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

Joanne Lynn, M.D., is Medical Director of Washington Home and Hospice, which cares for the elderly as well as the dying, and Assistant Clinical Professor of Health Care Sciences and Medicine, Division of Geriatric Medicine, George Washington University Medical Center.

From January 1981, to March 1983, she was Assistant Director for Medical Studies, The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Before that Dr. Lynn was Faculty Associate for Medicine and Humanities, Division of Experimental Programs, George Washington University, and Emergency Room Physician and Triage Physician, Washington Veterans Hospital.

In addition to her medical degree, Dr. Lynn has a Masters degree from George Washington University in Philosophy and Social Policy.

My concern as a physician with the issue of who decides and how we will decide arises from the experiences of patients and practitioners as they try to resolve these issues one by one. Our health care capabilities are increasing. Our health care expenditures are limited. Ours is a very troubling health care system.

A few of the grim statistics bear repeating:

- Children of the poor in this country, the richest country the world has yet known, are still twice as likely to die in the first year of life as children of the middle class;
- 10 percent of the population has no physician available and 20 percent has no way to pay a physician;
- one quarter of all physicians will not accept Medicaid;
- nearly one-third of needy children are excluded from Medicaid because their parents are married;
- health care costs are the most frequent cause of personal bankruptcy.
- *health or well-being for each individual who is suffering from a disease or a disability.* This is the usual justification for health care — the treatment of sickness in a person.
- *autonomy or self-determination, where each individual is able to direct the course of his or her life, both through the choices they make in health care and by having a reasonable range of choice left once they're treated.*
- *well being for the whole society.* You are familiar with the Adam Smith notion of economics in which each person pursuing his own best interest ends up benefiting the whole. We have largely pursued that notion in health care. Each person or each person and physician pursuing their own best interests is supposed to end up benefiting the whole. Unfortunately, people can expend more and more resources and sometimes do things that are deliberately harmful to the whole in pursuit of their own best interests. Very often patients can, in fact, harm others in an indirect way by pursuing their own best interests.
- *an equitable allocation of the benefits and burdens of health care across the populace.*

At the turn of the century when we only lived until the middle 40s that probably wasn't very important. Health care had very little to offer. My mother remembers being an intern when World War II broke out and realizing that the only useful things she had to offer patients were surgery, morphine and blood transfusions.

The panoply today is much more extensive and, along with perhaps an enlightened understanding of what it is to be part of society and to live in a community, we have come to see health care as not the sort of thing that you can have or not have as your means allow; health care should bear some relationship to your needs in a more direct way to your means of attaining it.

It is generally true that pursuit of the two goals for individuals — the patient's well-being and self-determination — have been the responsibility of the patient and the physician (with other health care personnel), have been secured through insurance bought by the beneficiary, and have been assured mainly through the enforcement of malpractice and informed-consent laws. By contrast, the pursuit of the latter two — the well-being of the society and equitable allocation of burdens and benefits across the society — has been the job of legislatures or those para-government officials who run Blue Cross perhaps, though it has been a job often done only half-heartedly.

Over the past two decades, standards have evolved to effectuate a justifiable balance between the pursuit of individual well-being and self-determination. Although there is still much to be done in assuring that all patients are actually offered the chance to direct the course of their health care and that the best treatments are offered, the standards that allow one to assess the merits of various practices are fairly well settled. In contrast to the attitudes of the first half of this century, physicians now routinely tell patients diagnoses and therapeutic possibilities and are slow to proceed with treatment without an adequate consent. Only for certain profoundly handicapped persons — largely infants and very old people — does overwhelming uncertainty remain, and there it arises because we are uncertain about what should count as benefiting these persons.

However, there is no such general agreement regarding the appropriate balance between the goals for the society as a whole and those for the individual. Should some one person forego a substantial but costly benefit so that others, to whom he is related only by virtue of being in the same society, can receive an even more substantial benefit? Should those who now can obtain nearly any treatment have to give up some of those options so that others might have some fair range of possibilities?

And the underserved have been largely the unseen. We have found in the last 30 years or so that it is difficult to turn down health care for those who are identifiable and show up in front of us. It's been hard to identify those who suffer from lack of preventive health services. For example, who is it exactly who suffers for lack of a prenatal feeding program? It's hard to tell. Or those who can't get health services because of geographical or cultural barriers? Who can't show up for health services? It's hard to identify the victims. It has become politically more acceptable to curtail the program.

In times of fairly vigorous economic growth, these questions were not so pressing. In the mid '50s we had an expanding economy and, since then, the percent of GNP going for health care has doubled. All goals could be pursued without regularly requiring trade-offs between them. We could resolve imprecision in defining the goals by applying more resources to making available interventions of even dubious merit, rather than requiring painful and troublesome examinations of their actual merit.

> Health care costs are the most frequent cause of personal bankruptcy.

Now that the economy is shrinking or at least not growing at the rate it would have to, and the public has come to the realization that they have other priorities that they would like to attend to, we must now begin to make careful tradeoffs among the pursuits of these goals.

It becomes clear that if we really want health care to be distributed evenly we can't allow people as much self-determination as they have been used to. We can't allow people options that are exceeding costly and have very small return. We can't allow people to pursue the kind of health care that they might be able to afford but that in doing so they would reduce the chances of those who are less well off of getting the health care they need.

Let us assume that society should, in the words of the President's commission, "ensure an adequate level of health care for all citizens without excessive burdens." What would we have to do to achieve this? First, we would have to accept that limits must be tolerated. This is a humbling recognition for this proud nation. We would have to go further and recognize that in health care, limiting beneficial care is always going to create an identifiable victim. We are going to have to learn to carry on a responsible public debate that acknowledges personal tragedy without thereby allowing that tragedy to unravel justifiable policies which restrict marginally beneficial care. At present, nearly any such policy can be doomed by publicizing an appealing victim.

Say, for an example, that an identifiable sub-group of persons with multiple chronic organ systems failure and advanced years are likely to live for only a short time if they require dialysis for superimposed kidney failure and that the combined costs of treatments are exceedingly high. A rule barring dialysis for this group could almost invariably be overturned by finding a mentally alert grandmother of 10 who spends her time reading books for the blind and interviewing her on "Nightline." By morning the rule would be dead. No politician could sustain it. The political pressures would be overwhelming.

Since even the best of policies in health care that restrict access to beneficial care engender identifiable victims, and almost all are certain to have some appealing victims, we shall have to learn to tolerate having them if good policies are to be developed and utilized.

Second, we shall have to assign responsibility for rationing services. Here, we are truly stymied. The only two groups now proffered as allocators are frontline

health care professionals and health care policy formulators. Health care professionals cannot decide which care to forego as being disproportionately expensive when they deal with individual patients for that would regularly put them in a conflict situation. Physicians must ordinarily serve the interests of their patients and themselves as it is. Now they would also be expected to serve the interests of the society at large. When the society would be better off if a patient were allowed to suffer harm, surely the patient's physician is expected to advocate for the patient. If not, patients will have much less cause to rely upon the judgment and reassurance of the physician.

> Physicians may be an odd group to place in the position . . . of judging who is worth living.

A professor of mine said we want two kinds of physicians. When we are well, we want a Marcus Welby physician to take one case per week and solve all possible aspects of it, including the social considerations. When we are sick, we want some bastard whose mother was a tyrant at toilet training, and who says, "You can't leave the hospital until the last test is done." And we don't care if he goes off a bridge at 42.

There's a certain truth to that. When people are very sick and dependent upon someone else for their very life they probably don't want to worry about whether that person thinks they're worth it in some grand social scheme.

Furthermore, physicians may be an odd group to place in the position to judge the merits of various allocations. They are largely members of a narrow social class and personality type and might well be rather prejudicial against some segment of society and some kinds of care needs. Almost all physicians are white, male and middle class. All have put off substantial personal gratification for many years and they are almost all serious obsessive compulsives. They've invested in mental life as opposed to religious or even physical life. They might be an odd group to put in the position of judging who is worth living.

One might see all the problems associated with turning physicians into door keepers and therefore turn to policymakers. They turn out to be no more well-suited to the task. They cannot overcome the aforementioned problems of harming a named individual. For those who must face the electorate, endorsing programs that effectively bar named individuals from needed health care seems a certain route to unemployment. For those who administer private programs, such barriers are likely to create difficulties in marketing.

There turns out to be no suitable allocators. The reason is basic: There is no societal consensus on what should count as a good allocation. How should we proceed?

First, we should mitigate the degree to which beneficial health care must be rationed and limited by decreasing wasteful practices and increasing efficiency in the delivery of health care. That's not a particularly ethically troublesome problem, although it may be practically difficult.

Second, we can look to increasing the resources that are devoted to health care. I know at present we think that on the order of 10.5 percent to 11 percent of GNP going to health care is entirely too much, but there is really no automatic upper limit. We must compare our health care needs with other things we would like to invest in and perhaps we should forego a few more bridges or MX missiles. Every once in a while, we should stand back and see if we can increase the size of the pie that we need to divide up. Next, we should shun harmful short-term resolutions such as having physicians become allocators. And we should resist reducing the access of the poor to health care.

Both of those are politically appealing options. It's appealing to do something nasty to doctors, after all. And it is certainly appealing to cut out programs that reduce access of those we like least: the poor, the elderly, the institutionalized. Those people are put again at risk of having their access to health care reduced.

Third, we should develop societal definitions of justifiable allocation policies, of what kinds of benefits are too small to warrant what kinds of resource utilizations.

We should really have a vigorous debate about such grand interventions as artificial hearts and also about such minor interventions as sustaining a severely demented patient in a nursing home.

Or a really serious debate over the infant "Doe" issues. You know, it isn't so obvious that severely handicapped infants should have their life sustained, merely because it is possible to do so. Yet, that is currently our public policy. This is probably best done on multiple levels simultaneously and first done on chronic and not life-threatening diseases. Otherwise, an intelligent resolution is sure to be blocked by strong emotion.

Fourth, we must modify various statutes that make it virtually impossible for health care providers, both individual and institutional, to effectuate even reasonable rationing plans. People forget there are laws that insist health care maximally benefits the patients. I can't be expected to limit some beneficial care for the good of society and simultaneously be unable to utilize that defense to a charge of malpractice.

If we are able to start on those things in this society, perhaps we will learn to ration rationally, to pursue social justice in justifiable ways. If we are not, we will learn even more nefarious ways of excluding the unseen. We will save resources by curtailing expensive lives of those least able to object, such as nursing home residents or profoundly handicapped persons, and by failing to serve those who can be kept from presenting themselves for health care. These outcomes are so reprehensible that they should motivate all persons of good will to redouble their efforts to secure a more ennobling resolution.

Q In terms of equal access for all, what about people who end up needing health care because they take risks by smoking, drinking, or riding motorcycles, compared to people who end up there through no fault of their own?

A Callahan: I think that's a lovely example of trying to find a system that's exceedingly rational. Under some theories, one ought to penalize people for their misconduct or their behavior when it becomes a burden to others. I think the question is an extraordinarily complicated one. First of all, we certainly don't know enough psycho-dynamically to understand how free people are in their choices. Anyone who's tried to give up smoking or has seen people starting to smoke knows how complicated that whole business is. People do not necessarily smoke voluntarily. They smoke because of bad habit, bad influences or what have you.

Secondly, it seems to me that we're really asking what kind of community we want to live in. I would argue that part of living in a community with others is bearing their stupidities and bad habits and not just what's good about them. The price of putting in a policy of penalizing those who took on voluntary health risks is that if we pushed it logically we would have to refuse admission to motorcycle riders who were hurt on the streets. We would have to engage in rather fascist means of finding out about people's bad behavior. Some people may not smoke but they resolutely refuse to get up from watching TV or stop drinking their six-pack every night.

We are going to have to go after those people also. That's going to take a Gestapo state to find and act against such people. When one thinks about it, the price of putting that into effect might be to make some wrong presumptions about why people behave the way they do and also to impose upon society a kind of health fascism that I think we would all regret.

Q I'd like to know your opinions as experts in the field whether you think there's a natural or political right Americans have to health care.

A Callahan: I've come to be rather skeptical of the use of the language of rights in this particular realm. Asking whether people have a right to health care is also to ask whether we have an obligation toward each other to support our needs in time of illness. It seems to me it's a rather hard case to make. I'd rather put the question in terms of the providing of a minimal basis of health care necessary to have a decent humane society.

I would want to say "Yes." It's hard to imagine having a society where there would be obvious life-saving things available, which were denied to people simply out of lack of generosity and spirit. That is almost to say that people have a right to make a claim upon their neighbor. I think most arguments that I've heard really want to strictly use the language of right and put a right to health in the same category as the right to free speech, as a kind of positive right against certain negative rights. I think that's a harder case to make. And I don't think it's necessary to make that case in order to have a very strong moral argument for providing minimal health care for everybody.

Q Some of us elderly in Rhode Island believe that we should join the 23 other states and have a living-will bill passed by our legislature. Do you feel that might help curb some costs? Do you approve of the living will?

A Lynn: I think living-will legislation should not have any substantial impact on cost. You should be able to do everything you want to do with or without the legislation. I believe you have a durable power-of-attorney statute now that would allow you to name a person to make your decisions for you, anyway, or you could get a guardian who should be able to make those choices. The choices of the living will should already be legal, with or without the statute. The statutes for living wills are more important in terms of public relations than for establishing any binding nature to the document. The documents themselves must be written so broadly that they require interpretation at the time of application and the entire meaning of them is in that interpretation. What is "heroic means?" What does it mean to be eminently dying?

We have different definitions of those terms and since the definitions carry the impact I don't think the legislation helps. The real fight is whether people are going to dictate the terms of their dying, and they already should be able to that without the statute. You may feel more comfortable about it with the statute passed.

As to whether it affects the cost, there are two ways of looking at that. One is, it certainly would reduce the cost of high-technology interventions near the end of life for most older people. In my experience most older people do not want their dying prolonged maximally by the kinds of things I can do for them.

On the other hand, what they may want to choose instead, and which right now is very hard to get, is decent, humane hospice-type care. That is also very expensive care.

So if, in fact, people really can advocate for how they want to be taken care of as they die, it might turn out to be quite costly. But instead of paying for respirators, dialysis machines and hi-tech doctors, it might be to pay for nurses, and hand-holders and home health aides. But those are not low-cost endeavors, either. So allowing people to dictate how they die may cost us a great deal.

Q You both made excellent cases for the need of a process for broad-based input into the development of policy in this area. What evidence do you see there is a desire or a consensus among the health care industry and the medical profession that this indeed should happen?

A Lynn: The one that I would hold up as a paragon is a marvelous endeavor that was undertaken in Oregon over the past year and a half called "Oregon Health Decisions" in which a group of people held meetings all over the state. It ended up involving one out of 10 adults. The forum discussed what kinds of trade-offs they thought should be undertaken. People have a number of criticisms of what they came up with, but in terms of a process it was really very dramatic to have that many people involved.

I think the kinds of things that would come out of that sort of endeavor are not likely to be major redirections of legislative efforts and new legislative initiatives, but the headlines are less likely to read "Evil health care system conspires to do in child who can't get liver transplant." Instead, it might change to "Yet another hard choice confronts Oregon voters," or "Oregon citizens: how will we decide what to spend money on?" That is an important shift.

Health and Lifestyle

Jonas Salk, M.D.

Founding Director and Distinguished Professor in International Health Sciences, The Salk Institute for Biological Studies

Dr. Jonas Salk received his M.D. in 1939 from New York University College of Medicine. He soon began the studies which have formed the core of most of his life's work. In 1942 at the University of Michigan he began studying immunization against influenza. He continued his research at the University of Pittsburgh in 1947 where he also initiated his studies on poliomyelitis. His work classifying polioviruses led eventually to the development of a noninfectious or killed poliovirus vaccine which induced immunity without infection. The vaccine's safety and effectiveness were demonstrated by field trials in 1954 and the vaccine was licensed for public use on April 12, 1955.

Dr. Salk has continued his work in immunological research, branching out more recently into the study of auto-immune and neoplastic diseases such as multiple sclerosis and cancer.

In 1963 he founded the Salk Institute for Biological Studies to bring together scientists and scholars from different fields of biological research who shared a common interest in sciences and a concern for the implications of their work for man and for society. The Institute today is involved in the development of basic biological knowledge through the study of molecular-cellular mechanisms in genetics, immunology, and neurobiology as these apply to diseases such as cancer, diabetes, and myasthenia gravis; to the problems of genetic defects, fertility control, aging, and alcoholism; and to the origin of life.

Dr. Salk was the Institute's Director until 1975, when he became its Founding Director. In 1984 he became the Institute's Distinguished Professor of International Health Sciences.

Early in the course of preparation for my career as a physician, I began to appreciate the importance of science and a scientific approach to all things that concern human life. This approach includes all of which we are capable, and includes a considerati... of human creativity. This university ... such a creation and that which c... mes from it, and the creative people in it.

At the time I started out on my career there was a great need for bringing medicine into the scientific realm. As I look back on what has happened since, I have become very mindful that, in a way, we're suffering from our success. It is almost as if we are experiencing too much of a good thing. And too much of anything is too much, even of good things.

As I listened to the discussions, I began to appreciate what it is that has moved us to be here together, to consider these profound questions, questions that really have to do with how we can regulate ourselves, how we can begin to recognize the importance of human values, and how we can face and question our values. There is no doubt that, as time has gone on in the course of human history, we have observed an evolution in our value system.

I've been asked to speak about — "lifestyle and health" or "health and lifestyle" — however, since this not my field professionally, I shall take some liberties to offer some thoughts and reflections on the question of lifestyle and health from a somewhat different perspective.

Frequently I hear the word "health" being used interchangeably with "medicine." When we talk about health care, when we talk about our health care dilemma, we're speaking about our medical care dilemma. I'd like to distinguish between medicine, which is concerned with disease and with reducing the negative, and health which is related to enhancing the positive. In the case of disease, it usually is the result of the

breakdown of a part. When we speak about health, it is usually to refer to the wholeness and the intactness of a fully vital human being. We talk about well-being, we talk about wellness.

I was reminded today of something that William Osler once said. "If you want to live a long life, choose a chronic disease and take good care of it."

This is what accounts for the seeming paradox of those patients who have a disease, but who are really not sick. If they take good care of themselves, and let the disease take care of itself, they're likely to make the kind of accommodation that will allow them to accept that limitation and to overcome it. I can give you no better example than that of Franklin Delano Roosevelt. Many young people were not aware of his affliction of paralytic poliomyelitis because he kept it hidden in some way.

But in some instances, a handicap can become a spur to even greater accomplishment and achievement. We see this in many people who seem to have been born again after a recovery from a serious illness.

So, there is no antinomy between medical care and health care. They can go side by side. My preference is to consider them both necessary, both important. But they are fundamentally different disciplines, they require different attitudes.

The emergence into prominence of this question about America's health and medical care dilemma has broad implications, not only for now, but for the future. I see this as the process of scientific, social and cultural evolution and it is from this vantage point that my observations and reflections will be made.

To provide a frame of reference, I would like to link this current interest in the relationship of lifestyle and health to the changes that have occurred in the 30 years since vaccination against poliomyelitis was first introduced. In its time, poliomyelitis came into prominence in the wake of such changes in lifestyle as improvements in hygienic conditions.

As a result of the many changes which have occurred — among which were improved sanitation and nutrition, the introduction of vaccines, and the availability of chemotherapeutic agents and antibiotics — the problem of infectious diseases has been resolved to a great extent in this country and the more developed countries of the world. Moreover, the advancing science and technology of prevention will soon include the development of many new and improved vaccines against the important infectious diseases of humans.

All this augurs a major evolutionary change in the ecological relationship between humans and pathogenic microbes and will have a significant effect upon the quality of human life, especially in the developing world where microbial plagues still occur. In the less developed countries, the relationship between lifestyle and health is altogether different from that in this and other developed countries.

As I noted, the emergence of polio as an epidemic disease occurred with improvements in hygienic conditions; this had the effect of postponing exposure to polioviruses beyond the time when the infant is naturally protected from paralysis by maternal antibody when a harmless immunizing infection would occur. Postponement of exposure to infection to beyond six months of age results in the risks of paralysis upon later exposure to naturally occurring virus. We see then that advances in civilization are a mixed blessing. Fortunately, however, through developments in science and technology it was also possible by vaccination to bring about the control of this undesirable side effect of those improvements in hygiene which also resulted in reduction in infant mortality and an increase of life expectancy at birth.

However, we now face problems associated with continuing advances in still other realms of human endeavor and accomplishment. For example, we are now confronted with syndromes associated with lifestyle changes that influence the state of health and well-being and the patterns of disease seen from conception to death.

When seen in broad perspective and from a different conceptual viewpoint — from that of diseases attributable to a single cause to that of diseases attributed to complex causes — we see the nature of the difference between those amenable to simple, and those requiring more complex, interventions.

If you want to live a long life, choose a chronic disease and take good care of it.

I will not exhaust examples that reveal the differences between the problems confronted earlier in the century, or even 30 years ago, and now. However, I want to draw attention to the difference in the forms then and now of the major health and disease problems of infancy and childhood, of adolescence and young adulthood, and in the mature adult and later life. The patterns have changed and they are different in the two worlds — the developed and the developing world — and even in the two worlds within our own country in which we see marked differences among those in upper and lower socio-economic groups, in blacks and whites and in the different ethnic groups.

The subject matter that now concerns epidemiologists the world over includes all aspects of physical and mental health as well as healthy and unhealthy behavior, not only of individuals in their personal lives but of individuals functioning as public servants and as leaders of communities and nations.

The purpose of extending our perspective in this way is to draw attention to the differences in patterns of lifestyle and health in the past and in the present and to draw attention to the future because of the rapidity with which it is advancing toward us. This is necessary because of the influence that we can now have in our capacity not only as guardians of our own health, but the health of the next and future generations.

The question with which we are confronted may be posed in any of a number of ways, one of which might be to ask if we can develop and maintain a life of such quality as to remain physically and mentally healthy and filled with vitality and resilience until the time encoded in our genes has expired.

If this is a reasonable form of the question, then we might ask what life events might be avoided or experienced to bring about the desired effect of enhancing health and reducing disease and preventing premature death. If this be the question, then it may well be necessary to deal with what is commonly called lifestyle and to develop a science of health and a corresponding and appropriate technology for health and well-being.

With this question in mind, I keep imagining that it should be possible, in dealing with pathogenic lifestyles, such as those associated with health-destroying behavior, to "immunize" in some way before crippling becomes established. I have the impression at times that a form of infantile paralysis is still with us caused now, not by the viruses of poliomyelitis, but by the paralysis or failure to resist the crippling effect of drugs, alcohol, and teenage pregnancy, or in the development of lung cancer and pulmonary and heart disease attributable to cigarette smoking.

It is not too far-fetched to suggest that someday there may be developed appropriate means for "immunizing" against the crippling behavioral afflictions that become established in the transition from infancy to childhood, from childhood to adolescence, and from adolescence to adulthood. "Immunization" in this instance refers to what may be thought of as behavioral modification to prevent or avoid victimization upon exposure to the kinds of temptations that lead to the development of pathogenic or pathologic lifestyles which then result in physical and mental disease for which treatment may be no more successful than was true for poliomyelitis.

This seems to be a rather strong assertion for which there may be little or no justification. However, it may not be too far-fetched to consider developing means to prevent the initiation of the process whereby addictions and other health-destroying practices become established. Enough is known about the formation of health-promoting and health-destroying habits to suggest that someday we will know enough to be able to facilitate the formation of health-enhancing habits and to avoid the development of health-destroying habits. Both tendencies may be said to be genetically possible and which will dominate may well be a matter of choice. It may be a matter of developing the *will* to make the health-protecting choice. If this be true then it suggests a point of departure and a direction in which we may look as we consider what might be done now to prevent lifestyle-related diseases, and to activate lifestyle possibilities for maintaining and enhancing health.

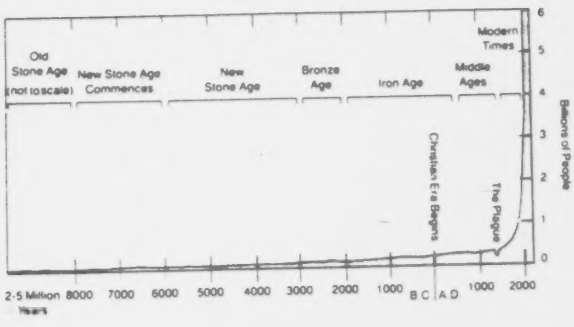
It is not necessary to wait for some indefinite time in the future to begin to think this way or to apply the knowledge we now possess. We know a great deal more than has as yet been applied. If we were merely to use what we now know we might find that far more can be accomplished than by any new knowledge still to be developed.

This, too, is a rather strong assertion, the justification for which may also be questioned. However, when one considers the correlations between cigarette smoking and cancer and heart disease, for example, and between alcohol and accidents as well as cirrhosis of the liver and brain damage, and the failure to use contraceptives by teenagers, and the disruption of one's own life and the lives of others, then we see how much pathology could be avoided by applying what we now know to avoid or prevent health-damaging behavior which would include nutritional habits as well as distress-provoking lifestyles.

To all this I might add the destructive effect of our addiction to war, our addiction to the making of more and more military weapons of all kinds which will either never be used or, if a few are used, the rest will be unnecessary. The consequences of all this is the depletion of our resources which deprives us of the use of such resources for maintaining and enhancing the health of individuals, communities, nations, and the world as a whole.

We are passing through a most important transition or phase change in human evolution. In the past we struggled for

World Population Growth Through History



survival — the survival of the individual — and now it is for the survival of the species. In the past our strategies have been *against* disease and in the future it will be *for* health. It can be said that in the past we struggled to survive; now it seems, that we must struggle to evolve, if we are to find the next step in our evolutionary trajectory as a species as well as in our personal lives.

If you observe the long trajectory since human life appeared on the planet, and if we go back to the period of the Old Stone Age, through the New Stone Age, the Bronze Age, the Iron Age, and up to the Middle Ages, what has been happening in modern times in terms of world population is rather different from what had happened before. It was not so long ago on this time scale that the plague occurred — the Black Plague that decimated one-third to one-fourth of the world population.

If we correlate the rise in the number of people on the face of the earth with the different periods and observe the human population trends, we see that in the nomadic period the change was not so great. It began to increase in the agrarian period. With the advent of the scientific-industrial age a little over 100 years ago, something happened that had not been true before.

Looking at actual numbers, we observe that over the next 100 years world population will reach a size of roughly 10 to 11 billion. The lower estimate is eight billion and the highest estimate is 14 billion. We are presently at about 4.7 billion, and the estimate is that it will be about six billion by the end of the century.

You can recognize that the challenge — as well as the problems — has only begun.

There are striking differences in terms of the population projections in the more developed world, and the less developed world. If you think that there are differences now, you can appreciate that they

> We see then that advances in civilization are a mixed blessing.

are going to become even more striking as time goes on. It's for this reason that I have turned my attention as much toward what goes on in the developing world — the so-called less-developed world — as in the more-developed world.

On this kind of a time scale, it's clear that something explosive has happened and is happening, and if this is the trajectory into the future, we must observe that we are both privileged to live at this time but, at the same time, we might be perceived as victims of an event that has gotten out of control.

What interests me now is the question of how best to manage a natural phenomenon such as this in which something explosive has occurred as a product of the human mind and of human creativity, and how can the human mind and human creativity be brought to bear to deal with it.

In terms of three periods, the first period might be thought of as dynamic equilibrium — equilibrium at a rather low level of numbers of people on the face of the earth for which there were adequate resources. We are now in a second period. We are just about at a point of inflection, moving toward a period in which there will be dynamic equilibrium, but at a higher level of numbers demanding more resources and requiring much more interdependence and mutualism than presently prevails.

This is an abstraction taking away all of the details of the fundamental process now going on. The direction of things is now undergoing a major change. Until now, what was of positive value might very well, if continued, be of negative value. It suggests that what is of positive value now, if it had dominated in the past, might very well have been of negative value.

So we seem to be going through a phase change that is not merely quantitative, but qualitative. The dynamics of the process up to this point, and the dynamics from this point forward will have been — and are — quite different.

Qualitatively, we have reached this point through strategies which might be called anti-disease and death-control. We have had great success, and have increased the carrying capacity of the planet, with the increased availability of resources. We now must shift our strategies to what I call pro-health and birth control, meaning that we must restrict numbers in a sensible way and make the most of the lives that have been saved. The concerns

at one time were in respect to quantity of children, and now I think it's quite clear that in this society the concerns have to do with quality of children.

I was in China recently and was terribly impressed by the change in attitude toward human life associated with the restrictions in the number of children per family. That will be an interesting experiment to observe. It will change from one or one-and-a-half children per family to two to maintain the dynamic equilibrium. But in the course of time, the attitudes toward human life are going to undergo a radical transformation. That has not yet taken place in those parts of the world where they are still suffering from a high infant mortality, a relatively low life-expectancy and the conditions of existence in which, perhaps, eight or 10 children might result in three or four able to take care of the fields and provide for themselves and their families.

Concerns in the past have been largely quantitative, but we're going to be shifting our attention from numbers to quality. From the discussion here today, it is quite clear that this is something about which we are becoming conscious and aware, are coming from a different direction, and for different reasons.

How are we going to consider the future? Will these two sets of values continue to go their separate ways, and will the world be divided into those who espouse one set of values, attitudes, and strategies, and others who espouse the other? My contention is that it would do what the serpents did and become cozy and begin to recognize the greater strength that comes from this kind of mutual reinforcement, so as to reduce the necessity for either-or strategies and consider, rather, the kinds of strategies that will lead to interaction.

Let me let you see what the two different worlds are like in terms of the age distribution of the population. In the more-developed countries such as the U.S., the proportion of individuals in the older age groups is much higher than in the less developed countries, where it's the reverse — where the highest proportion is in the lower age groups. Even if population control were applied now and one were to achieve zero population growth in the less-developed countries, it would take 50 to 70 years before equilibrium would become established because of the fertility of the group still to reach maturity.

On the other hand, what is happening in the more-developed countries is going to happen in the less-developed countries. Already they are seeing what is almost an epidemic of stress-related diseases, the kinds of diseases that they've never seen before. But with the influx of people into cities, unaccustomed to living under those circumstances, the same syndromes are beginning to become evident in the as-yet less-developed countries.

> In the past we struggled to survive; now, it seems, we must struggle to evolve.

Let's look at the differences between these two worlds in terms of life expectancies. The developing countries are still far behind the more-developed countries, and there is beginning to be a plateau — suggesting that we are reaching a point that would be limited in terms of life expectancy by our genetic pre-conditions. Nevertheless, we are now confronted with the challenge to see what we can do about increasing the quality of life throughout the lifespan, and there are some who are now interested in studying, not the diseases of age, but rather, successful aging. They are interested in trying to understand the resiliency that is found in those in the older age groups, sometimes affectionately referred to as "the aging superstars," people who still have a great deal to offer, a great deal to contribute, and who will — and can — be drawn upon as a very important resource by virtue of their wisdom and greater experience.

So, even in this field, we're beginning to see evidence in support of the contention that there is a shift in attitudes, values and strategies from anti-disease to pro-health, and therefore, this interest and concern with health might be seen as a way of reducing the burden of medical care. In a way these are two interrelated phenomena and we can look to the economy that is associated with prevention as contributing to an answer to the problems of the burden of medical care. That also shifts the responsibility from others to oneself, and this leads to a whole new and different philosophical orientation which is, in my view, in itself very healthy because it makes us aware of the power that we possess and the control that we have in exercising an influence over our own destiny as individuals and collectively — and that we are, in a sense, the co-authors of our destiny.

If what I've been saying is true and if the more optimistic view is taken and we recognize that these two trends or tendencies have always existed and that something happened at a given point in time to divide the world into two parts, then the time will come when some form of reconciliation will be necessary and hopefully it will come before we tear the world apart.

This is an abstraction, suggesting the anatomy, you might say, of the reality with which we are confronted. If this be true, then we can see the kinds of reconciliations that will be necessary in order to bring about wholeness and health and to bring about integration of a differentiated planet, to integrate the needs and the contributions that can be made, each to the other.

The same thing will prevail as we begin to consider material value and human value. What is of greatest interest is how much concern we now begin to hear about human beings, human values, human compassion in the determination of making judgments and decisions relative to material value.

The changes that we are about to see are evolutionary. I prefer to call them evolutionary, rather than revolutionary, because I think it is part of the normal process of evolution of which we are the product, and of which we have become

the process, able to steer and to direct the course into the future.

We can see the struggle between large-scale and small-scale — it's something that's occurring constantly. We see the struggle between the modern way of life and the traditional way of life, and the need to reconcile these different strategies and attitudes between Western thought and Eastern thought, between science and art, natural and social sciences and the humanities, institutional and individual values and considerations. We come to a world divided into two ideologies: individualism and collectivism. Reconciliation will be a summation of what will be necessary in all aspects of human life — the recognition of the need for what I called individual mutualism, a mutualism in which we will recognize the greater value of bringing out the best, not only in ourselves, but in others, individually and collectively. When that becomes the order of the day, it will become as if our objective and our purpose in life will be to make healthier human beings.

You can see the connection between this and what we have been talking about this evening, about health and lifestyle, and about the need that we have to understand the relationship between the two.

It's going to be necessary to have what I call a "science of health," a science that will look at human nature as it is, and take it as it is, and attempt to understand how we can deal with human nature which is *not* immutable, which is influenced and can be influenced. It is by virtue of our adaptation that we have arrived where we are today. This institution would not exist if that were not in our genes. Now we have to learn how to use ourselves and our institutions more wisely.

If we need an increase of anything it is creative wisdom and wise compassion. It may well be that in the past we have had enough wisdom to deal with the amount of knowledge that we had. Now, we have so much more knowledge than ever before that it may well be that we are lacking sufficient wisdom with which to cope with the knowledge that we now possess.

We might ask ourselves: "Who is responsible for the situation — for the predicament in which we find ourselves? Who is to blame?" And we might ask, "Can we agree upon a prescription?"

I suggest that no one is to blame. This has come about as a result of our success. We are the beneficiaries and the victims at one and the same time. We will constantly be confronted with problems and challenges of this kind, and it is for this reason that I'd like to introduce the notion: in answer to the challenge Einstein stated when he said that, "With the splitting of the atom everything changed, save our way of thinking, and for survival we need a new way of thinking."

Atomic energy is a product of the process of evolution. What we need is what I call an evolutionary way of thought, as distinct from thinking in terms only of survival. We have carried to the ultimate the development of means for survival against adversity — against enemies. We now have the perfect weapon with which to destroy our enemies, but unfortunately it would destroy us at the same time.

Therefore, there is another strategy that is waiting to be applied. These are evolutionary strategies requiring an evolutionary way of thinking, of being and of behaving. If this be so, might this be the prescription? How would we apply it?

This then is the challenge and it's for this that I say we need a science and appropriate technology. But we have to agree on what is the objective of our attention if it is in this direction that our creativity is to be applied.

If we need an increase of anything, it is creative wisdom and wise compassion.

How can we develop ways and means of carrying our youth through a kind of passage-rite that would allow them to become more aware of what is in their own best interest? Until such time as we can discover that, might we consider drawing upon the young who have demonstrated their wisdom among their peer groups, those who seemed to have avoided the difficulties that some have gotten into, and through some kind of buddy system help each other overcome these vicissitudes?

I don't think that any of these problems are insoluble. I do believe that we need a new way of thinking, and if we can begin to think of ourselves in these terms and as instruments of the process of evolution, then we will develop the necessary ways and means for applying ourselves in this way. Not only for the benefit of the entire world, but, even more importantly, because it will mean the fulfillment of our own biological potential.

References: "World Population and Human Values: A New Reality" by Jonathan and Dr. Jonas Salk (New York, Harper & Row, 1981) and "Anatomy of Reality: Merging of Intuition and Reason" (New York, Praeger, 1985; originally published New York, Columbia University Press, 1983)

Access to Care — I: Where Are the Holes in the Net?

Gail Wilensky, Ph.D.

Vice President, Domestic Division, and Director, Center for Health Affairs, Project HOPE

Gail R. Wilensky has been Vice President of the Domestic Division and Director of the Center for Health Affairs for Project HOPE since April 1983. The primary focus of the Center is on the role of the private sector in the financing and delivery of health services as well as its role in cost containment.

Prior to joining Project HOPE, Ms. Wilensky was Senior Research Manager, National Center for Health Services Research, Department of Health and Human Services (1978-1983), where she designed and directed the National Medical Care Expenditure Survey.

She has also been a Health Service Fellow, National Center for Health Services Research, Department of Health, Education and Welfare, a Faculty Associate at the Survey Research Center, Institute for Social Research, University of Michigan, Senior Research Associate, The Urban Institute, Washington, D.C., and Executive Director of the Governor's Council of Economic Advisors in Maryland.

Access to health care was a major issue of the 1960s and early 1970s. Concern about access to medical care for the uninsured, the poor, and the aged — traditionally disadvantaged groups — led to the passage of Medicare and Medicaid in 1965.

In addition to these major federal programs, there were numerous other initiatives such as community health centers, rural and migrant health centers, the National Health Service Corps, and a host of maternal and child care programs. These programs were designed to increase access to health care by extending insurance coverage to the aged and poor, directly providing health services to certain disadvantaged groups, and the provision of additional physicians in areas in which there were perceived shortages.

Since the mid-1970s, however, the major focus of public policy has been on cost-containment activities. At the federal level, several attempts were made to pass hospital cost-containment legislation. While these attempts were notably unsuccessful in the 1970s, the speed with which the prospective payment legislation passed Congress surprised even its most avid supporters. State governments and the private sector have also been very active over the past five or more years. States have introduced a variety of rate-setting programs, and the private sector has initiated numerous initiatives such as increased cost-sharing and utilization reviews.

Recently, the issue of access to care has re-emerged on the national agenda, although it has shown little indication of displacing cost containment. There are several reasons for this: the earlier shift in emphasis from access to care to cost-containment, proposed and realized reductions in domestic spending, the increased emphasis on block grants, and the recent recession have combined to cause renewed concern about access to care for disadvantaged populations in the United States.

It is not clear where we stand today because of inadequate and/or conflicting data. However, there is some amount of evidence that access to care problems for traditionally disadvantaged groups — particularly the uninsured — probably increased slightly between 1981 and 1983.

some have suggested that gains achieved since the '60s have been lost. On balance, it appears to me that they have not.

It is even less clear where we are today — a year and a half after the latest available data. Since the economy has improved substantially during that period, one might presume that access to care should be improving for at least those portions of the population which are benefiting from the economic expansion.

There are at least three different types of access measures which one could consider in examining whether the magnitude of access problems and access to care has changed over the past decade. The easiest and perhaps best proxy for access is the number of uninsured. Individuals who are uninsured are not only financially vulnerable in the event of illness but they can also be shown to use health services at substantially lower rates than insured individuals, even when they are ill.

While the lack of insurance affects access to care, the presence of insurance may not mean the absence of problems, since insurance can vary substantially in terms of its coverage.

The age group most likely to be uninsured are young adults ages 18-24.

A second set of measures used to reflect access examines the actual process of receiving care, or utilization. Whether or not the individual has a regular source of care, the location of the regular source of care, waiting time to see a physician, percent seeing a physician or having a hospitalization, and medical procedures received by adults and children during a year are some of those used.

A third set of measures which are sometimes used to reflect access are health status measures. While these measures ultimately reflect the single most important outcome of the health care system, one should interpret changes in health status as reflections of changes in access only with great caution. It should be obvious that changes in the health status of a population or subpopulation are the outcome of a great number of forces, of which access to care is only one.

In the second half of the 1970s and through 1980, the overall uninsured population at any given point was just under 12 percent. This population was composed of almost two equal sized groups — 18-plus million (8.5 percent of the total U. S. population) who were uninsured for at least a year and 16-plus million (7.5 percent) who are uninsured for only part of the year. Of this 16 million, there were more than five million individuals who had Medicaid only part of the year and who were otherwise uninsured.

There are several characteristics of those who are always uninsured which are worth noting.

- the age group most likely to be uninsured are young adults ages 18-24;
- one-third of the uninsured are under age 18;
- half of the uninsured are from families with (1977) incomes above $15,000;
- over half were employed all or part of the year;
- approximately 70 percent of their dependents were employed.

Thus, while the full-year uninsured are disproportionately poor and disproportionately out of the labor force, the majority are (or were) neither predominantly poor, nor predominantly unemployed and out of the labor force.

There are several studies that have data on the number of uninsured since 1980, although they have as yet not yielded a clear conclusion. The 1982 National Survey of Access to Medical Care showed approximately the same number of uninsured between 1982 and 1976 when similar adjustments were made to the data to account for different data definitions.

The 1982 Census showed an increase of about 4 million uninsured from 1979 to 1982. The problem is that the 1979 Census produced an inaccurate estimate of the uninsured. Insufficient analysis of the 1979 survey has been done to indicate why the 1979 estimate was unacceptably large relative to other consistent estimates, nor which sub-population groups appear to be responding inaccurately. Given the difficulty with the 1979 estimates, and the use of approximately the same questions in 1982, it is difficult to know whether the difference between the two reported Census numbers is meaningful.

Some recently released data from the Census Bureau's new Survey of Income and Program Participation for the fourth quarter of 1983 show a distinct increase in the number of uninsured, to 15 percent. This new and important survey will provide data for a 2 5-year period showing not only the level of health insurance for each quarter, but also the way in which health insurance coverage changes with income and employment.

The data reported to date, however, have only just been announced and therefore have not been subject to further independent analysis. Until that can be done and associated with estimates from later surveys, it is difficult to know how "reliable" the increase is. The 1982 and 1983 Health Interview Surveys will also provide another source of information on the number of insured during these periods. These are surveys which are done each year by the National Center for Health Statistics on a national probability sample of the U. S. population.

These data sets do not clearly indicate the size of the uninsured population in the early 1980s. Further analysis will prove useful. However, they do seem to indicate that there may have been a slight increase in the number of uninsured in 1982 and 1983. There are no data more recent than the fourth quarter of 1983.

Whether the sharp increase in unemployment in 1982 caused an increase in the number of uninsured is not known, but it is important to remember that we face a very different economic picture in 1985. In the fall of 1982, unemployment peaked at a rate exceeding 10 percent of the work force. In the summer of 1983, unemployment was more than 9 percent; by the fourth quarter it was about 8.5 percent. The current unemployment rate is 7.3 percent. Although relative to the early 1980s, we have lost jobs from heavy industry and gained jobs in the service sector. The latter has provided less extensive coverage. Nonetheless, given the current unemployment rate of 7.3 percent, even with the shift in job sectors I believe the number of insured today is closer to the estimates of 1980 than whatever the uninsured estimates turned out to be relative to the recessionary period in 1981 through 1983.

Although many studies measuring access have been done over the years, there is only one study based on national data which represents experience after 1980 — the 1982 National Survey of Access to Medical Care.

According to a recent report that analyzes the 1982 Access Survey, the relative distributions of people who have a regular family doctor, those who have a usual place they go but not see a particular provider, and those with no regular source of care have all remained fairly stable over the period 1970 to 1982. Their report also points out, however, that low-income, minority and uninsured populations continue to be more likely users of hospital outpatient departments and emergency rooms.

Differences between the rates at which low-income and minority populations and

It is the uninsured who report consistently the most problems regarding access.

the rest of the population contact physicians have continued to diminish over time. Those without a regular source of care or who are uninsured, however, continue to have the lowest physician contact rates. Hospitalization rates were down slightly relative to 1976, continuing a long secular decline, although overall they remain relatively constant. The variation between subgroups also remained about the same.

The use of preventive measures are frequently regarded as good indicators of access to care. There has been an increased proportion of women having Pap smears or breast exams in 1982 relative to 1976. The rates for non-white women compare favorably with those of white women for Pap smears in particular but low-income, uninsured, or publicly insured women are still less likely to have these procedures. Preventive medical procedures received by children increased between 1976 and 1982 for low-income, non-white, and uninsured children, although in the case of TB skin tests, a differential between these groups remained.

The 1982 survey collected important data on several special access problems which individuals experienced during the year. Two percent of the population, for example, reported that a serious illness had caused financial problems. The groups most often affected by this problem were the poor, the unemployed, those out of the labor force, and particularly the uninsured. The numbers, however, remained quite small throughout, generally not exceeding 4 percent.

A larger number, 6 percent, reported that they needed help but did not receive it. Again the unemployed, the uninsured and minorities were disproportionately represented — with the uninsured having the highest representation (15 percent) in this category.

Two percent of the population also reported that they were refused health care for financial reasons. Again minorities, the unemployed, the poor and the uninsured are disproportionately represented, although here the variation around the number was quite small.

A final measure used was the percent who found it more difficult to get care in 1982 than in 1976. Although the overall number was quite small — 2 percent — it was located disproportionately in two groups, the unemployed and the uninsured. Some favorable progress has been made and some traditionally disadvantaged groups became more likely to have regular family doctors or private insurance coverage or have been to a doctor or had certain preventive tests and procedures.

Nonetheless, relative to the economically or socially advantaged groups, gaps remain. While minorities, the poor, the unemployed and those with public coverage or no coverage were more likely to experience financial difficulties as a result of major illness or have experienced greater problems in obtaining care than other groups, it is the uninsured who report consistently the most problems regarding access.

A final measure which can be used to reflect access to care problems are health

status measures, particularly infant mortality rate. There are, of course, many factors that affect health status besides access. It was recently reported that while the infant mortality rate continued to decline in 1983 and 1984, it did so at a much slower pace than the average annual decline of 4.6 percent a year between 1965 and 1982. The rate of decline between 1982 and 1983, however, was only 2.7 percent and it appears that between 1983 and 1984 the decline was less than 2 percent. There are several reasons for this moderation in the rate of decline:

- declining rates of return on technologies which save low-birth-rate babies;
- government restrictions on Medicaid and grants to states for maternal and child health;
- stabilization in the number of women receiving prenatal care in the first trimester.

While the moderation in the decline in infant mortality rates represents much more than just an access problem — good maternal nutrition and the avoidance of smoking, drinking, and drugs — access problems may also have contributed to the decline. It is currently estimated that the percentage of pregnant women receiving prenatal care in their first trimester of pregnancy has stabilized at 76 percent.

So, access problems clearly remain. The uninsured population had been estimated to be about 12 percent on an average annualized basis, and as much as 16 percent of the population experienced some periods without insurance during the year. It is unclear whether and by how much the number of uninsured increased during the period 1981 to 1983. Some reports suggest that it remained rather stable; other reports suggest that it increased either modestly or even substantially. The resolution of that debate will require later estimates and further analyses.

In any case, it is likely that the number of uninsured has declined since the 1983 level given both the lowering of the unemployment rate and the expansion in the number of jobs. In addition, while some progress seems to have been made between 1976 and 1982, differences between the traditionally disadvantaged groups and the rest of the society remain. Also, there is some evidence that they may have been hardest hit by the effects of unemployment and eligibility and benefits for health programs. This is particularly true for the working poor.

Finally, at least one frequently used health status measure — the infant mortality rate — has almost plateaued after a decade and a half of gradual but steady reduction. While the causes of the plateau are complex, it is worth noting that only 76 percent of women in their first trimester are receiving prenatal care, reflecting a combined problem of access and education.

If the size of the problem has not increased in a major way, what is the explanation of the renewed focus on access to care problems? In part it is the natural concern associated with the severe recession we experienced in the 1981-1983 period. More important factors, however, have been the increased emphasis placed by policy makers on the prudent buyer concept; the heightened awareness of medical care costs by employers in their role as major purchasers of health care; and the declines in hospital revenues which have resulted from Medicare's prospective payment system.

These market-oriented reforms have forced more explicit recognition of the groups which have traditionally been outside the insurance sector and which have had their care financed in an implicit matter via cost shifting.

If hospitals are to stay competitive and to remain in the black, as most are legally required to do, it is forcing us to recognize once again the numbers of our population who are outside the system. That recognition, rather than the increased numbers, is the source of the renewed interest in access to care problems.

The infant mortality rate has almost plateaued after a decade and a half of gradual but steady reduction.

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Access to Care — II: Where Are the Holes in the Net?

Sara Rosenbaum, J.D.

Director, Child Health Division, Children's Defense Fund

Sara Rosenbaum has worked with the Children's Defense Fund since 1979. The Child Health Division, of which she is Director, engages in research, policy analysis, legislative and administrative advocacy, and litigation, and offers technical assistance to states on health care financing issues and federal maternal and child health programs. The Division is particularly concerned with general issues involving access by the poor to timely and appropriate health care.

Before coming to the Children's Defense Fund, Ms. Rosenbaum worked as Staff Attorney, National Health Law Program in Los Angeles, and Staff Attorney, Vermont Legal Aid.

In 1981 Ms. Rosenbaum received the Beneficiary Services Award, Health Care Financing Administration, U.S. Department of Health and Human Services, for distinguished national service on behalf of Medicaid beneficiaries.

Carmela Mendoza, a 16-year-old Texas resident, was admitted in labor to an Austin hospital on August 14, 1983. Carmela's family was poor and had no health insurance. Carmela had received no care during her pregnancy. Her labor was rapid and spontaneous, and thus according to hospital officials "there was no opportunity for transfer." She gave birth to a baby girl, weighing three pounds, seven ounces, which is slightly more than half the normal birth weight, which placed her at high risk, due to Carmela's total lack of prenatal care.

Four days later, despite the risks facing the baby, hospital officials discharged Carmela and her daughter. While the hospital admittedly had no facilities for treating high-risk infants, no attempt was made to transfer the baby to a more appropriate institution. Hospital officials noted later to investigators that the hospital did "not have a minimum weight requirement for infants to reach before they are discharged." No attempt was made to arrange any follow-up health or social service care for the mother or the baby. When the infant was discharged, she still weighed less than three and one-half pounds.

The next day, on August 19, Carmela returned to the same hospital with her baby. The baby was "eating poorly and felt warm." After trying to bring the baby's fever down, the attending doctor began a search for a neonatal intensive care bed for the infant. One was finally found at another hospital's regional neonatal center, and the baby was transferred there by ambulance.

Carmela's baby then spent 25 days in the intensive care unit. The discharging doctor noted that Carmela's baby had been inappropriately discharged initially by the first hospital at such a low birth weight, because she was suffering from failure to thrive, "exaggerated bilirubin," and "at risk for developing anemia of prematurity as she grows." The discharging physician arranged to enroll the baby in the WIC program, a federal program providing food supplements and health care to poor women and children at nutritional risk, and to have her followed by a nurse.

The average cost of neonatal intensive care is about $1,000 a day. For a total of about $600, Carmela could have received comprehensive prenatal care, including vitamins and nutritional supplements. These steps might have avoided the greater human and financial costs

In the United States, where national health expenditures totaled about $350 billion last year, millions of infants, children, and pregnant women fail to receive necessary health care.

■ In 1982, one of every 20 pregnant women and one of every 10 pregnant black women received either no prenatal care or none until the final three months of pregnancy; among pregnant women under the age of 20, one in nine received little prenatal care or none at all. Babies born to women who receive no prenatal care are three times more likely to be born with low birth weight, and low-birth-weight infants are 20 times more likely to die in the first year of life or to suffer handicaps.

■ one of every four black children and one in three Mexican-American children did not see a physician at all in 1980. Even among children who were sick, black children received only three-quarters of the medical care provided to white children.

■ one of every three black children has never seen a dentist.

The underlying cause of these disturbing facts is poverty. Today, poverty is rampant among children. In 1983, one of every four children under the age of six and one of every two black children lived in poverty. With poverty comes inadequate health insurance and, thus, inadequate health care. In this country, insurance is the key to obtaining adequate medical services, but we have no national health policy that ensures publicly funded health care for all who cannot afford to purchase it. Our current public health system and charity services are grossly inadequate to meet the needs of the uninsured and is growing more so.

By 1982, 32.7 million Americans under age 65 — one person in six — had no health insurance. The majority of the uninsured are poor; almost two thirds have family incomes that were less than twice the federal poverty level. By 1982, the number of uninsured Americans living in poverty had grown to 32 percent.

The uninsured are not only growing poorer — their numbers have increased significantly. The problem of medical indigency, which has always been serious in the United States, has spread rapidly in recent years. Because of family income and employment status, the rise in unemployment caused by the recent recession has led to an increase in the number of uninsured, from 14 percent to 16 percent of the under-65 population.

The disinsurance caused by the recession has been exacerbated, some believe, by changing employer insurance purchase arrangements in the work place. Many employers, in an effort to cut costs, are now limiting health insurance coverage for working families. Younger, less well-paid workers with young families may be particularly affected by this trend. The Congressional Budget Office has estimated that 50 percent of America's uninsured children live with an insured family head whose employer-provided health insurance does not include the rest of the family.

Just as the problem of poverty disproportionately afflicts children, so does uninsuredness. Children are over-represented among the uninsured. While children under 18 comprise 17.5 percent of the U. S. population under age 65, they make up 36 percent of all the uninsured persons under 65. Today, 11.7 million children under age 19 — one in every six children — has no health insurance. One in every seven women of child-bearing age, or 6.6 million women, is uninsured.

For children who are both poor and uninsured, the picture is particularly grave. There is no health care "safety net" for them; there is neither health insurance nor the money to pay for medical services. Unlike poor senior citizens, these children cannot fall back on government-sponsored health insurance coverage provided by the Medicare program. Two of every three poor or nearly poor children are either uninsured or are insured for only part of each year.

Extensive research has documented that persons without health insurance are significantly less likely to have access to necessary care.

■ Studies comparing the use of hospital and outpatient medical care among individuals in fair to poor health found that the uninsured sick received 50 percent less hospital care and 75 percent less ambulatory non-physician services.

■ In its 1982 study of Americans' access to health care, the Robert Wood Johnson Foundation found that one million families were refused care when they sought it because they were unable to pay for it. The study also found that the poor were almost twice as likely as the non-poor to be unable to obtain any care.

■ A federal study examining the health status and health care utilization patterns of uninsured widows and children receiving Social Survivors' benefits found that while children in these families were twice as likely to be sick than those in the general population, the uninsured children received only 75 percent of the medical care received by children in the general population.

■ Researchers at the National Center for Health Statistics found that, adjusting for health status, the poor received substantially fewer services than the non-poor. Disparities in the use of important preventive services were particularly striking. Low-income women were less likely to receive prenatal care, Pap smears, and breast exams, and young low-income children were less likely to be immunized.

Furthermore, there are indications that access to medically necessary care has been reduced even further in recent years.

■ After a decade of progress in the 1970s, during which increasing numbers of women received prenatal care in the crucial first three months, this upward trend had all but stopped by 1982. For black women, the pattern actually began to reverse itself. Between 1979 and 1982, the percentage of all women beginning prenatal care in the first three months of pregnancy remained unchanged at 76 percent. Among black women, the percentage receiving early care actually declined between 1981 and 1982 from 62 to 61 percent. Additionally, the percentage of women receiving late or no prenatal care increased from four to five percent among white women and from nine to 10 percent among black women.

One of every three black children has never seen a dentist.

■ A recent unpublished paper sent to state health agencies by former Assistant Secretary of Health Edward Brandt reported that the decline in national infant mortality rates had slowed significantly, resulting in an infant mortality plateau of the type that had not been seen since the decade between 1955-1965. In addition to pointing to the nationwide erosion in timely prenatal care noted above, the report also found that state data suggested an actual increase in post-neonatal infant deaths. Such a trend was particularly disturbing to department officials because, unlike neonatal deaths which are most sensitive to hospital intervention, the post-neonatal death rate is heavily influenced by an infant's environment and is substantially more preventable.

These disturbing health statistics mean that the health care improvements for infants which were a hallmark of the 1970s are slowing or, in some cases, actually reversing themselves as we approach 1990. They point in the opposite direction of the goals that we as a nation have set in the area of public health.

In 1979 the surgeon general of the United States established the following objectives for the nation in the area of infant health:

■ By 1990, 90 percent of all pregnant women should receive prenatal care in the first three months of pregnancy.

■ By 1990, no more than five percent of infants should be born at low birth weight, and no more than nine percent of infants from any racial or ethnic subgroup should be born at low birth weight.

■ By 1990, infant mortality rates should not exceed nine deaths per 1,000 live births, and infant mortality rates for racial or ethnic subgroups should not exceed 12 deaths per 1,000 live births.

These objectives were recently reaffirmed by the surgeon general of the current administration.

This year, the Children's Defense Fund undertook its second annual national survey of state vital statistics on infant births and deaths to measure the nation's progress in meeting these three modest goals. The survey, which included a review of national natality and infant mortality statistics from 1978 to 1982 and a review of state natality and infant mortality data between 1982 and 1983, revealed the following:

■ The nation's rate of progress in improving pregnant women's access to early prenatal care is so slow that, unless our annual rate of progress improves by 600 percent per year between now and 1990, we will not meet the surgeon general's goal for prenatal care. For non-white women, the annual rate of progress must improve by 700 percent per year in order to meet the goal.

> The health care improvements for infants which were a hallmark of the 1970s are slowing or, in some cases, actually reversing themselves as we approach 1990.

■ The annual rate of progress in reducing the number of infants born each year weighing 5.5 pounds or less is equally disappointing. Unless the rate of progress improves by 300 percent each year, the nation will not meet the surgeon general's goals.

■ Progress in reducing the number of black infants who die each year is so slow that the nation would have to boost its annual rate of progress by 170 percent each year to meet the surgeon general's goal.

The nation's rate of progress in meeting these goals is literally a matter of life and death for thousands of babies. Between now and 1990, 22,000 babies will die in America, primarily because they were born too small to survive. Many more will be handicapped for life. We can prevent 2,700 of these deaths — one of every eight — simply by ensuring that expectant mothers receive adequate prenatal care. Another 13,800 deaths in which low birth weight plays a major role may be reduced if mothers receive early prenatal care.

As the number of uninsured poor has swelled and the demand for free health care has grown, an increasing number of health care providers are cutting back on the amount of subsidized care they will provide. Cost containment, cutbacks, and competition for shrinking private and public health insurance dollars means that no one wants to compete for the uninsured.

The health needs of the uninsured are putting a heavy cost burden on hospitals. According to information collected by the National Center for Health Statistics as part of its annual National Hospital Discharge Survey, about a half million women who delivered babies in hospitals in 1983 were uninsured.

It has been estimated that 40 percent of all hospital care for the uninsured patients involves obstetrical cases, and that this care adds up to over $1.5 billion per year in hospital charges. The number of uninsured obstetric and pediatric cases is so high that according to a recent statistical profile of the source and distribution of uncompensated care in American hospitals, two of every three white female patients in southern public hospitals will be uninsured this year. In north central hospitals, one of every two white newborn females will be uninsured. In western hospitals, two of every three white newborn female infants will be uninsured.

Even more ominous is the fact that uninsured newborns represent the most expensive charity care cases that a hospital can treat, thereby increasing the pressure on hospitals to stop providing services to these babies. At one hospital, for example, high risk newborn infants represented only one percent of all uninsured patients but nearly 20 percent of all uncompensated care charges imposed by the facility. An average hospital bill for a high-risk newborn in Georgia exceeds $11,000, and yet babies are more likely to be born to women who, because of poverty and lack of health insurance, are the least able to afford the cost of care. It is the very

poorest and least uninsured babies who are in the greatest need of care and who ultimately may be the least able to get it.

Given the pressures for cost containment and the large costs associated with caring for medically indigent women and children, there exists a real danger that hospitals will begin to reduce the amount of indigent care they furnish. There are already warning signs of this trend. Between 1981 and 1982, 15 percent of hospitals serving large numbers of poor patients adopted specific limits of the amount of charitable care they would provide. Some hospitals, apparently in response to the high cost involved and the large numbers of children who cannot meet those costs, have cut back on the intensive care service they will provide to any children. These trends indicate that the cost of caring for uninsured children can indirectly constrict the availability of services for all children.

Such reductions on specialized hospital care for women and children are dangerous for even deeper reasons. Between 1965 and 1979, infant mortality rates declined by more than 40 percent in the United States. These dramatic declines were not the result of more preventive health care and the birth of healthier babies; instead, they were the result of the development of very specialized intensive infant care hospital services that now permit us to keep babies alive who would certainly have died 20 years ago. While the number of babies in need of care is not declining, these special services are in danger of shrinking, and the number of babies whose families cannot afford to pay for them is growing.

The largest public health program for mothers and children is Medicaid. It represents 55 percent of all public health funds spent on children. It accounts for 26 percent of all hospital payments, public and private, made on behalf of children under age six, 17 percent of all hospital payments made on behalf of adolescents, and 30 percent of all payments for hospital deliveries of teenage mothers. Medicaid has dramatically improved women's and children's access to health care, and has consequently been linked to improved health status among newborns and children. This program has also helped ensure that hospitals have a large enough pool of paying young patients to sustain a full range of essential child health services.

Moreover, Medicaid is cost effective. Researchers have demonstrated that for every dollar spent to provide comprehensive maternity care for Medicaid-eligible pregnant women, two dollars can be saved in the first year alone of an infant's life because of improvements in birthweight rates and a consequent reduced need for hospital care. Preventive health care for Medicaid-eligible children has been shown to reduce health problems and has cut program costs by nearly 10 percent for children who receive it.

Yet, even prior to the recent growth in medical indigency, the program was seriously inadequate. Medicaid reached fewer than half of all poor children in 1980. In 22 states the program actually reached less than 40 percent of children living in poverty.

There are two reasons why Medicaid reached so few poor children. First, states maintain very restrictive categorical eligibility standards. Over half of all states still fail to provide coverage for children aged five and older in two-parent families no matter how poor they are, simply because two parents live at home.

Second, states have frozen financial eligibility requirements for the program at extremely low levels. For example, in some states, the monthly Medicaid financial eligibility standard for a mother and three children is less than 25 percent of the federal poverty level.

In the past four years, while childhood poverty was soaring, the number of children receiving Medicaid benefits was declining. The growth in poverty added over three million new poor children to those in need, bringing the total number of poor children in 1983 to 13.3 million. Yet, both Medicaid and the Aid to Families with Dependent Children (AFDC) programs (eligibility for which generally determines a child's entitlement to Medicaid benefits) were simultaneously reduced. Moreover, in all states, the AFDC program has failed to keep pace with inflation. For these reasons, the number of children receiving Medicaid actually declined by nearly 700,000 between 1981 and 1982 and by over 200,000 between the 1982 and 1983 fiscal years. At the same time that childhood poverty was increasing, the number of children receiving Medicaid benefits was declining.

The decline in the actual number of Medicaid recipients tells only part of the story, however. The comparison of Medicaid usage during the 1974-76 recession and the rate of utilization during the recession that reached its peak during 1983 presents a stark contrast. When the recession of the 1970s was at its height, the number of Medicaid recipients per 100 children in poverty stood at approximately 95 percent. Had this correlation been present in 1983, 12,635,000 children would have received benefits. The actual Medicaid child recipient count for 1983, however, was 10,743,633. This figure thus represents not only hundreds of thousands fewer recipients than in 1982, but signifies a decline of almost two million children when compared to the program's performance levels during the recession of a decade ago.

Between now and 1990, 22,000 babies will die in America, primarily because they were born too small to survive.

Finally, even for children who do receive it, many states' Medicaid benefit package is inadequate. The level of benefits provided is at the option of the individual states and thus varies. Both the services covered and the extent of coverage are too limited to address the range of health problems the poor face.

For example, over a dozen state Medicaid programs place major limits on the number of inpatient hospital days for which they will pay. In at least five of these

states, hospital coverage is limited to fewer than 30 days per year while some infants need longer stays. In these states high-risk newborn infants and very sick children who face extended hospital stays and possible rehospitalization are placed in jeopardy, since providers may decide not to serve them because their insurance is inadequate to pay for the full extent of care they need.

Other states now limit the number of visits beneficiaries can make each year to physicians' offices and clinics, so many high risk pregnant Medicaid beneficiaries who need much more frequent medical attention during and after pregnancy may find themselves without the health insurance to pay for it.

Moreover, many states have reduced or frozen Medicaid provider reimbursement rates in order to save money. Lower reimbursement rates have resulted in a shortage of physicians who are willing to treat Medicaid recipients in many areas. In Massachusetts, for example, critical obstetrical shortages are reported in both the western and eastern parts of the states. Similarly, the administrator of the Suffolk County, N.Y., Medicaid program reports that several hundred Medicaid recipients in one of the nation's wealthiest suburban counties gave birth last year with little or no prenatal care because no obstetrician would treat them.

> Over a five-year period, more American children die from poverty than the total number of American battle deaths in the Vietnam War.

Residual public health programs are markedly inadequate. For example, the Title V Maternal and Child Health (MCH) Block Grant program, while much touted, is a small source of maternity and pediatric care for poor women and children. While the program provides prenatal care to hundreds of thousands of pregnant women and checkups, immunizations, and specialized care to several million children, it is able to furnish only a fraction of the care that medically indigent women and children need. In 1982, for example, state MCH agencies were able to provide prenatal care to only 409,000 women, and this figure includes many women insured by the Medicaid program. Hundreds of thousands of uninsured women gave birth that year in excess of numbers served by the program. Moreover, only 37 percent of pregnant women served by Title V agencies — less than 50 percent of the national average — received care in the first trimester of pregnancy. Seventeen percent of women who received prenatal care from public health agencies through MCH that year — over three times the national average — received no care until the final three months of pregnancy or received none at all.

In addition, some 128 migrant health centers reached families in the migrant stream, a population in which almost 20 percent of women — four times the national average — receive little or no prenatal care and in which nearly half of all women have experienced at least one out-of-hospital birth. Studies have shown that community and migrant health centers deliver care that is high quality and cost effective and that can reduce hospitalization rates between 25 and 44 percent. Yet today, while 25 million Americans still live in medically underserved areas, community health centers serve only a little over five million persons.

For the fifth consecutive year, in the face of the highest child poverty rate in 18 years, President Reagan has targeted poor children and families again for billions of dollars in new budget cuts.

Under the fiscal year 1986 Reagan budget, children will lose $5.2 billion. By 1990, children will lose $37.6 billion in federal support. This is on top of $10 billion a year in cuts already made in survival programs for children and families since 1980. By 1990, if Reagan administration budget priorities succeed, every American will be spending 19 percent less on poor children and families and 86 percent more on the military.

At the same time, the Reagan budget proposes a $32 billion increase in defense spending over last year. This is on top of $178.3 billion in defense increases since 1980. By 1990, if the President's defense proposals are carried out, the military budget will increase by another $344.2 billion, or 239 percent, to make American children more "secure" from external enemies.

American children need defense against the domestic enemy of poverty. A study of childhood deaths conducted by the state of Maine, indicates that over a five-year period, more American children die from poverty than the total number of American battle deaths in the Vietnam War. Yet, every poor American child could be lifted out of poverty in 1986 for less than half of the proposed defense spending increase for that year alone.

The Reagan administration proposes to take the following actions in in the area of maternal and child health:

- reduce Medicaid payments by $1.1 billion by placing a "cap" on federal Medicaid payments to states. Beginning in 1987, federal payments would be permitted to grow at the annual medical care inflation rate (currently 6.8 percent). The administration projects "savings" of $6 billion. This cut would be accompanied by changes in federal Medicaid law that would permit states to further reduce the number of persons they cover and the benefits they provide;
- abolish the Community Health Centers Program, the Migrant Health Centers Program, and the Family Planning Program and replace them with a block grant funded at 1985 levels;
- freeze funding for the MCH Block Grant at 1985 levels;
- freeze childhood immunization funds at 1985 levels.

All the proposed maternal and child health cuts would severely damage funding for maternal and child health services. Without question, however, the administration's Medicaid proposal would cause the greatest harm. Freezing federal Medicaid payments and placing a federal

growth cap on program funding levels would virtually destroy the program.

Since 1965, states have been able to draw down as many federal Medicaid dollars as needed to finance medically necessary health care for the poor. As previously noted, no state Medicaid program is currently large enough to meet the health care needs of all the poor and uninsured persons in the state. Some programs are exceedingly small in relation to need. As the problem of uninsuredness among Americans persists, and as the population grows older and its medical care needs grow more complex, state Medicaid programs face increasing pressure to grow in order to accommodate the needs of the poor.

In the face of this challenge, the proposed 1986 Medicaid funding cap would allow program growth of only three percent, less than half the medical care inflation rate, and thus an actual cutback in funding levels. States would either have to make up these cuts out of their own budgets or cut their programs. No program growth would be permitted over 1984 Medicaid service levels, regardless of the growth in medical indigency and regardless of the growing need for high-intensity care.

The President's immunization funding proposals are particularly grave. Between 1983 and 1984, the inflation rate for diphtheria-pertussis-tetanus (DPT) vaccines alone was 99.5 percent. At this rate, the money that purchased vaccine for 911,000 children this year will vaccinate only 450,000 children next year. And the 911,000 children given immunizations this year represent less than half of the 2.5 million children immunized under the program in 1981.

Just as dangerous is the administration's inadequate $4 million request for a "stockpile" of childhood vaccines. In 1983, after a series of vaccine shortage scares, Congress and the administration agreed that a six-month stockpile of polio and DPT vaccines should be built. The administration's $4 million request, however, is not enough to purchase even a one-month supply of DPT vaccines alone.

American babies need defense against preventable infant mortality and birth defects. For seven percent, or 25 days, of the defense budget increase next year, every poor mother and baby could be provided Medicaid, and thus prenatal care coverage. How many four-pound babies will it take to balance the federal budget?

How many four-pound babies will it take to balance the federal budget?

Tens of thousands of American preschool children need defense against preventable disease. Yet, while the President plans to build 17,000 new nuclear weapons over this decade at an estimated cost of $71 billion, his budget only allows for a single month's stockpile of DPT vaccination serum. Two million fewer children will be immunized against DPT next year than in 1981 because the administration's budget requests ignore the dramatically increased costs of vaccines and the unmet need. Half of all black pre-school children are not fully immunized against DPT and polio.

We must begin to face the nation's real choices for children. The Reagan administration in truth gives no heed to budget deficits. Its own budget, with a nearly $200 billion proposed deficit for next year alone, flies in the face of concern for a balanced budget. There is room in the budget for billions of dollars in tax breaks for corporations. Why is there no room for our children's health?

The President has touted the Grace Commission's recommendations for deficit reduction through social welfare program cuts. He has been silent about the fact that the W.R. Grace Company earned $684 million profits from 1981 to 1983, paid no net federal income taxes, and received $12.5 million from the government in negative income taxes through rebates or sales of "excess" tax benefits. If we just raised the Grace company's tax rate to zero, we could pay for nine million of the free school lunches President Reagan and the Congress cut from children. But the President proposes to cut $630 million from child nutrition programs in 1986. He is not planning to raise the Grace company's tax rate.

We cannot afford any more, Carmela Mendozas. We cannot afford to have our children born into poverty, hunger and ill health. These realities constitute our true national deficit.

Twenty-two years ago Dwight David Eisenhower said, "The problem in defense is how far you can go without destroying from within what you are trying to defend from without." The future health of mothers and children depends on the ability of policymakers today to recognize the truth of President Eisenhower's words two decades ago.

Access to Care — III: Where Are the Holes in the Net?

John L.S. Holloman, Jr., M.D.

Former President of New York City Health and Hospitals Corporation

John L.S. Holloman, Jr., M.D. was elected President of New York City Health and Hospitals Corporation in 1974. Before that he practiced medicine (1948-74) and served as Medical Director (1970-72) and then Vice President (1972-74) of the Health Insurance Plan (H.I.P.) Automated Multiphasic Testing Center in New York City.

Dr. Holloman has served as President of the National Medical Association, National Chairman of the Medical Committee for Human Rights, Chairman of the Califano/Rangel Harlem Health Task Force, and Staff Member of the Health Subcommittee of the Ways and Means Committee, U.S. House of Representatives (1979). In 1980, Dr. Holloman was appointed Regional Medical Officer for the Food and Drug Administration, Region Two, Brooklyn, New York.

Dr. Holloman is a member of the Institute of Medicine, National Academy of Sciences.

Health care in America is complicated by its origins and fragmented by serendipidous technological advances which build an impressive facade covering a "Rube Goldberg" framework, costly and cumbersome beyond belief. Most of the problems of our costly health care delivery system will not be solved by tinkering with financial mechanisms designed to add more or less money to a financially insatiable system with disordered priorities.

Yet, if there is a net, there are holes in the net. There have always been holes in the net; there are needs which our present health care delivery system cannot meet.

Share my thoughts as I list for you some of the problems of access that are now related to money. However, it should also be clear that some of the problems of access are related to other forces which are not money.

There is a story about a young resident physician who was visiting an emergency room of a public general hospital in a large city in the eastern part of our country. He was impressed with the wide variety of people that he saw in the waiting room. He thought "What a learning experience!"

He was not impressed by the long periods of time that some people had to wait. He was surprised to find that many of the patients waiting in the emergency room had no other source of health care. He was even more surprised to learn that some of those in the emergency room had private doctors, but that their services were not available. One emergency room patient told the young resident physician that his doctor liked for patients to get sick "by appointment only." Another patient said his doctor had no evening hours, made no house calls, had no x-ray or laboratory, accepted no Medicaid patients, and refused to accept Medicare assignments. The physician, the emergency room patient continued, always insisted on being paid in full in advance and charged the patient for filing an insurance claim for the patient's reimbursement.

For the young resident, this was a weekend experience. For the others it is *Hill Street Blues* and *St. Elsewhere* in living color.

The Health Subcommittee of the Committee on Ways and Means of the United States Congress led by Congressman Charles B. Rangel held hearings on the problems of financially distressed hospitals. The report gathers dust as these resources — i.e., hospitals, doctors, and other health care personnel — are disappearing from those communities which ironically have the greatest health care

needs. The public general hospital is an endangered species.

One of our greatest assets is a healthy population. Our population suffers needlessly if there are barriers to quality health care.

The President's Commission on the Health Needs of the Nation was created by the executive order of President Harry Truman in December, 1951, for the purpose of evaluating, among other things, "the degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities," and "the extent of federal, state, and local government services in the health field, and the desirable level of expenditures for such purposes." In its report to the President the commission stated:

"The maintenance of health must now be added to food, shelter and clothing as one of the necessities of living. . . . National neglect of proper measures for the preservation of health exposes the country to weakness and destruction. . . . We believe that access to the means for the attainment and preservation of health is a basic human right . . . (and) . . . the same high quality of health services should be available to all people equally."

Although I agree with those who have contributed to an understanding of access, I will try to define it more precisely as it is used with health care.

Many members of the Madison Avenue advertising industry use language in non-traditional or unconventional ways. Some of the companies selling private health insurance succeeded, without breaking the letter of the law, in deceiving patients about the extent of their health care coverage. An example is the private health insurance policy that proclaims complete and comprehensive coverage for everything in bold print on the first page of the policy contract. The exclusions and exemptions are listed in fine print on the next 26 or so pages, which are seldom read and understood by the unsuspecting purchaser who usually does not really plan to be sick (that's for other people).

Within the usual limitations of language I define "access to health care" as the freedom from barriers to health care. A barrier is anything that constrains, deters, delays, denies, dissuades, discourages, handicaps, or prevents the acquisition or utilization of those services that are ultimately provided by society to its members individually and collectively for maintenance, preservation, and improvement of health. Dying a dignified death in comfortable surroundings can be enclosed in this definition, since life is indeed finite.

In the United States, access problems involve large segments of our population. Some of the subsequent discourse will generate some understanding, if not agreement, with the position I have taken. For too many Americans, quality health care is a dream deferred. Their access is limited.

Poverty and race play an ironic role. It is ironic that among the major industrialized countries only two — the United States of America and South Africa — have failed to develop a national health insurance system or a national health service to more nearly ensure that quality health care is available to all their residents. The U.S. leads the world in per-capita income and expends more per person for personal health services than does any other nation. In the face of these facts, it is shocking to review the health statistics and realize just how much illness and untimely death is suffered by the poor in the United States.

For too many Americans, quality health care is a dream deferred.

Many volumes have been written about the correlation between poverty and ill health. It is a true statement that "the sick get poorer and the poor get sicker." In 1967 the U.S. Department of Health, Education and Welfare issued a publication, "The Delivery of Health Services to the Poor," which continued the documentation of this phenomenon observed over many years.

Working literally in the shadow of the Columbia University Presbyterian Medical Center, the late Edward Suchman studied some of the social correlates of medical deprivation. The observations he made during his study of health attitudes of a diverse ethnic population in Washington Heights, New York City, during 1960-61 would probably be reinforced by a follow-up study done today. Dr. Suchman found that lower-income families who were highly ethnocentric or who restricted social experiences to members of their own group had an unfavorable attitude about medical care. The study further showed that the stronger the degree of ethnocentricity, the more unfavorable the attitude was likely to be about medical care.

Ethnic minority groups tend to reinforce negative impressions and perceptions toward health providers on the basis of prevailing community attitudes, particularly in lower socioeconomic regions. In many black communities, a high incidence of disease may be directly related to the unconscious reluctance to seek early treatment because it is purveyed by non-black health providers, many times in a test atmosphere in which there is no informed consent.

In New York City, for example, since the 1966 implementation of Medicaid we have seen the growth of the shared health facility frequently called the "Medicaid mill." Simultaneously, we have seen a sharp decrease in the number of physicians engaged in the solo practice of medicine in less affluent communities. We've also seen a decrease in the solo practice of medicine in the more affluent communities, associated with the rise in inflation and with the rise in the cost of malpractice insurance.

In direct relationship with low Medicaid reimbursement rates we see a declining number of physicians who are willing to serve Medicaid patients in private offices. The result is that Medicaid patients are being driven back to clinics in numbers that exceed the pre-Medicaid days. This is a serious perversion of the intent of the legislators who enacted Title 19 of the Social Security Amendments of 1965. The estimates of the numbers of physicians who refuse to see significant numbers of Medicaid patients in "private" offices run

as high as 97 percent in New York City.

The "working poor" are people who earn too much money to be eligible for Medicaid and not enough money to buy insurance to pay for their medical care.

The third-party reimbursement rates for clinics and for hospital-based ambulatory care have failed to keep pace with the rapidly escalating cost of medical care. Ambulatory care deficits have increased. Many hospitals have cut their losses by decreasing the level of ambulatory care.

Many hospitals have cut their losses by decreasing the level of ambulatory care.

Hospitals have been forced to reduce or curtail their services to the poor. Many hospitals have been forced to move to affluent communities or to go out of business, as larger numbers of medically indigent, underinsured and uninsured patients are forced to seek care in these institutions that remain in the inner-city.

The federal government through the Department of Health and Human Services has designated certain areas that have been seriously damaged by loss of providers and facilities as medically underserved areas. These distressed areas should enjoy a high-priority role in the reconstruction of our cities and towns.

It is a frequent observation that some inner-city problems are aggravated rather than solved by some of the solutions. Urban renewal in too many instances is tantamount to removal of poor and minority persons. The gentrification of the west side of Manhattan is a classic example.

Access to quality health care is reduced by virtue of residence in a poor neighborhood. Many different studies have documented the synergism between poverty and ill health. The incidence of illness as evidenced by morbidity and mortality statistics is, almost without exception, higher in these federally designated medically underserved areas of our urban communities. Rural areas of affluence are usually better off, in spite of a reduced number of health care providers, than are the less affluent rural communities.

There is a maldistribution of physicians. The out-migration of the population to the suburbs has been directly associated with a similar out-migration of hospitals, physicians, and other health providers. However, it should be noted that urban areas of affluence have not suffered these losses. In fact, there has been a significant increase in facilities, physicians and other health providers in many affluent urban areas. The concentration of these health providers is particularly marked in places like Beverly Hills, California, the North Shore of Long Island (Nassau and Suffolk counties), and the fashionable east side of Manhattan, along Fifth, Madison, and Park Avenues — where physicians, hospitals, medical schools and other health providers are concentrated — and at times are so contiguous as to be sardonically referred to as "Bedpan Alley."

The Graduate Medical Education National Advisory Committee (GMENAC) predicts a surplus of 130,000 doctors by the year 2000. GMENAC recommends that no new medical school be established. No increase in entering classes should be permitted. There should have been a decrease of 10 percent in the number of medical students starting in 1984. The continued expansion in the production of physician assistants and nurse practitioners should be halted because of the danger of a glutted health-provider market.

GMENAC is typical of much that is wrong with our health care delivery system. It is limited in scope and vision and threatens to do much more harm than good. I like to call GMENAC "the Physician's Protective and Exclusion Program of the 1980s." It seems to be designed simply to prevent the development of an abundant supply of physicians in the future. One of my principal criticisms of GMENAC is the timid approach it makes toward confronting the problem of physician maldistribution. The American College of Surgeons is especially critical of GMENAC and seriously challenges its assumptions, its methodologies, and its conclusions.

Race, sex and nationality are factors in access barriers. The problems of access have significant implications for minority physicians and other health providers. The rise in the cost of a medical education has serious implications for health professionals drawn from the ranks of the poor. Minorities, including black and Hispanic persons, are seriously under-represented in the ranks of physicians. Blacks today make up something less than 2 percent of the physician population of the United States. Not just coincidentally, women are less than 30 percent of the physician population. In many of the nations of the world the majority of the physicians are female. This is particularly true in the larger socialistic countries, such as the People's Republic of China and the Soviet Union.

There is talk in high places about a physician surplus. Unless the health care delivery system is changed, with manpower being distributed according to demographic and medical need, nothing could be farther from the truth. It is true that a more equitable method of distributing health manpower could perhaps reduce the demand for physicians. But such is not the case today.

There is an incestuous relationship between poverty and ill health. There is no such relationship between health manpower and ill health. Manpower tends to follow the money; physicians tend to congregate where there is money, abandoning less affluent neighborhoods. Here, too, racism is superimposed on the problems of the poor.

Physicians may abandon poor neighborhoods and areas inhabited by racial minorities because they are afraid of bodily harm or loss of property (personal or professional), or because they can make more money in more affluent neighborhoods, or because they want to avoid the societal stigma and loss of prestige (social and professional) that results from association with minorities.

The question can be argued for a long time without final definition. It is a fact that those areas where our nation's ethnic minorities reside are nearly devoid of physicians and health facilities. It is just as clear that the manpower distribution does not adequately serve the needs of the ethnic and less affluent minorities. It is the

Q Dr. Holloman, in your comments you referred to ambulatory care facilities, "Medicare mills," community health centers and clinic-type operations, as being perceived as demeaning places from which to receive health care. Don't you think you're perpetuating access problems because certain minority, low-income people may not go to community health centers or other type of clinics because they don't perceive them as real health-care dispensers?

A Among the other things I do, I'm the medical director of a community health center and I certainly try to make that a very humanizing, warm experience. We try to make it as comprehensive as we can. The basic problem is the funding, particularly when we are dependent on governments for funding. It's at that level that we have to raise and lower expectations because of the things that are thought to be too good for poor people. Certainly the outreach services are not necessarily included. Those providers who are in the community health centers deserve all the credit that I can give them and if I gave the impression that they were doing a disservice, I would like to correct it at this time.

Some of the outpatient departments that we see in our larger voluntary and teaching hospitals could learn a lot from community health centers, because their approach may be sometimes quite different. There we find the step-down financing costs being shifted from inpatient to outpatient, so that it appears that care is being given when perhaps we are supplying and supporting some of the other services within the hospitals.

The waiting time in the outpatient departments and emergency rooms is very extensive. I had an experience going to Botswana once, and there was a worker who was injured. He was seen by the British Flying Doctor Service within two hours after he received his critical injury. The previous Saturday night, I had sat in the emergency room of one of the larger municipal hospitals and watched patients waiting for five to eight hours just for ordinary care since there were no family doctors in that community.

majority belief among blacks that the health care system, in addition to being classist, is racist.

One survey of welfare families found that 70 percent of blacks and 35 percent of whites felt their physicians were rude. More than 72 percent of the blacks and more than 46 percent of the whites agreed that doctors were prejudiced against people on welfare. And 67 percent of the blacks thought doctors were prejudiced against them.

The contempt for the poor is clearly a learned response on the part of the physicians, who are taught on clinic patients and perfect their skills on these so-called citizens. Once the skills are perfected, the physician then feels that he is good enough and absolutely free to sell his skills in more affluent areas, which are called "private." In the eyes of too many physicians the more affluent are more worthy of deferential treatment than are the poor. In our materialistic society the poor are thought by many to have had an equal opportunity and to have failed.

A 1982 survey by the University of Chicago indicates that non-whites are much less likely to go to a doctor's office than whites. Non-whites have less private health insurance than whites. More farm residents tend to be uninsured than urban dwellers.

The medically indigent is any person who fails to qualify for Medicaid, who is too young to qualify for Medicare, and is too poor to afford health insurance which is a fringe benefit for most employed persons.

The poor are homogeneous, often having only their poverty in common. Douglas A. Fraser, former President of the UAW, speaking about the problem of access:

"Significant portions of our population, particularly low-income workers, the poor, the ethnic minorities and those who live in the urban ghettos and rural areas, find it virtually impossible to get decent health care when they need it. Nearly 51 million Americans, typically those with limited resources and usually the most needs, live in areas without sufficient health services. Seeking care is often delayed to the point of being fatal and the few medical services that are received are often provided in such demeaning settings as hospital clinics, emergency rooms and "Medicaid mills." Millions of other Americans cannot get adequate care even if they have basic health insurance coverage. Having money in pocket to buy medical care does not necessarily mean it is available. It does not assure access nor assure that what is available is appropriate."

There is a need to recruit more women physicians. Access to health care has been limited by sexism. Traditionally in the United States, the white American male has dominated the medical profession. It was not until the feminist movement was re-ignited by the civil rights movement of the 1960s that it began to demand equal rights for women in medicine. The success of the feminist movement has been dramatic, nevertheless, the situation for women in medicine is still far from satisfactory.

We have to improve access for the elderly. The elderly as a class have been hit hard by inflation in the cost of health care. Medicare, since its inception, has covered a decreasing percentage of the health care expenses of the elderly.

For the elderly individual on a limited or fixed income, out-of-pocket medical expenses appear to be increasing at a frightening rate.

Many elderly individuals find that their "golden years" are uncomfortably enmeshed in unanticipated poverty. The lack of access to the necessities of life is becoming a fact of life for too many of our senior citizens. This painful situation is only partially relieved by charity, welfare and Medicaid. This state of dependency is not a just reward for a life of hard work and sacrifice.

Blacks today make up something less than 2 percent of the physician population of the United States.

It is clear that there is a significant disassociation between the need for care and the utilization of care. Since health care in

the United States is frequently most available to the affluent (regardless of need). similarly the highest quality care — including the concern for privacy and the consideration of human dignity — is most often available to the more affluent. The poor often seem less worthy.

Barriers to health care are less formidable for the rich. To the extent that physicians control the utilization of health services, we have already seen that more services tend to be provided when it is certain that money is available to pay for the services. Although patients are usually not the cause of the overutilization of health services, they are frequently cited as causative agents.

> Access to health care alone cannot overcome the adverse effects of ignorance, poor housing, hazardous employment, polluted air and water.

Teaching institutions generate problems because of their focus on the education of the students. This primary focus tends to reduce the status of the patient to that of "teaching material." Since patients are frequently off-limits to students, overutilization of laboratory studies and diagnostic facilities in this situation is clearly the responsibility of the teacher, rather than the patient.

However, access to the teaching institution is now related to reimbursement as much as it is to teaching functions. It is sometimes necessary to remind medical educators that education in our health care system should be a means to an end, rather than an end in itself. A clear national health policy would help to maintain this focus. It is of interest, too, that there are teaching institutions that obliterate all distinctions between patients, including both source of payment and source of referral, in order to afford a greater measure of equity and dignity to all. Clinic or "second-class" patients are thereby relieved to a large extent of the stigma of being considered merely "teaching material."

Access to health care alone cannot overcome the adverse effects of ignorance, poor housing, hazardous employment, polluted air and water, etc. However, it can do much to prevent mental retardation, sickle cell anemia, rickets and cretinism. The early detection of cancer in many cases has a life-or-death impact on the outcome. The controlled diabetic does not suffer the disastrous complications to the extent that the uncontrolled diabetic suffers them. Worldwide access to a little health care (smallpox vaccine) has eliminated a dread disease as a clinical entity. Although diphtheria is seldom seen today, a recent diphtheria outbreak in San Antonio, Texas, was most severe among those families whose access to health care had been sharply limited.

Where there is a widespread perception of inequality and lack of equity, the individual's motives and actions tend to become self-centered, thereby depreciating and diminishing concerns for society as a whole. Where there is advantage there is also disadvantage. Where individuals and groups profit excessively at the expense of the society, the society, if it is to survive, must protect itself from this counter-productive and ultimately destructive activity.

As I look to the future with proliferation of for-profit health care delivery organizations, I see enormous problems for those individuals and groups on which the profit is to be made. The business orientation demands a balance sheet which is written with black ink and pays dividends to investors.

Business and industry are becoming the major purchasers of private health care and are manipulating the health system by dumping their financial losses on the taxpayers. They are divesting themselves of their losses and thereby increasing the problems of access for those who have to use the public system to contribute to the profitability of the for-profit system.

The biggest barriers to quality health care for all Americans is the absence of a national health policy and a clear understanding of the reason for the existence of a health care delivery system.

If our great nation is to survive and reach its potential, it must reorder its priorities so that the materialism of the few will not destroy the humanity of the many.

Our net must be redesigned to serve all Americans at a cost which we can afford. It can be done and I think we should do it.

In 444 B.C., Aristotle wrote that health of mind and body is fundamental to the good life. If we believe men have any personal rights at all, as human beings they have the absolute moral right to such a measure of good health as society and society alone is able to give them.

I say to you, access is fundamental.

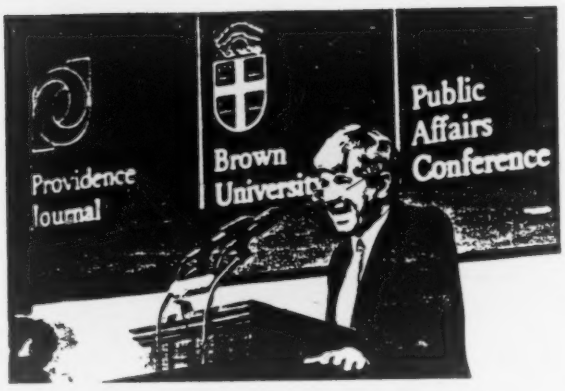
Q Can you explain why community health centers are viewed as being competitive with private practices and why there's a hesitancy on the part of the medical community to support increased funding to community health centers because they are viewed as competitive forces in the market-place?

A Many times, solo practitioners are unable to provide the services but are also unwilling for others to provide them. Some of the physicians in the poorer neighborhoods are not able to be a part of what they perceive as a colonial system, particularly if this is an operation that is operated from an ivory tower for pure study purposes, rather than for the compassionate delivery of health services as community health centers are.

Health Care and the Elderly

Carl Eisdorfer, Ph.D., M.D.

President, Montefiore Medical Center, Professor of Psychiatry and Neuroscience, Albert Einstein College of Medicine



Carl Eisdorfer has been President and Chief Executive Officer at Montefiore Medical Center in New York since July 1981. He is also professor of psychiatry and neuroscience at Albert Einstein College of Medicine with which Montefiore is affiliated.

Montefiore, one of the largest medical centers in America, is an organization of several teaching hospitals which provide long-term care, community health and outreach programs, and a national center for clinical and scientific research.

Before coming to Montefiore, Dr. Eisdorfer was Chairman of the Department of Psychiatry and Behavioral Science at the School of Medicine, University of Washington, Seattle, and Founding Director of the University's Institute on Aging. Dr. Eisdorfer had previously been Director of the Duke University Center for the Study of Aging and Human Development.

Dr. Eisdorfer has served on the Federal Council on Aging and the National Advisory Council of the National Institute on Aging.

His research, concentrated in the fields of aging, the behavioral sciences, psychiatry, and health policy, has led to new understanding of the psycho-biology of aging and of learning and intelligence changes in older people. It has also given new direction to the diagnosis and treatment of the impaired elderly.

It has now been two decades since President Johnson flew to Independence, Missouri, to have former President Harry Truman join with him in signing the Medicare and Medicaid programs into law. On that occasion, President Johnson proclaimed that "every citizen will be able, in his productive years . . . to insure himself against the ravages of illness in his old age. . . . No longer will illness crush and destroy the savings that older Americans have so carefully put away over a lifetime."

Today, we find that Medicare has only partially fulfilled its promise, and that the conflict between the growing needs of an aging society and a federal budget which has limited its social commitments has become the subject of one of the nation's most difficult policy debates. At the heart of this debate is whether we as a society should reaffirm, reject, or reduce the forceful commitments we made when Medicare was enacted 20 years ago. To understand how we have arrived at today's dilemma, it is important to begin by looking back at the political, demographic, epidemiological and technological changes which have occurred in recent years.

The advent of widespread insurance coverage for the payment of hospital and medically-related costs in the United States dates back to the late 1920s and the Blue Cross/Blue Shield program. The program involved a voluntary effort to organize primarily middle-class workers in an effort to spread the risk of medical and hospital costs. From the 1930s, Social Security set the stage for Federal involvement in pensions and established the magic number 65 as a landmark age in the United States.

At the same time, changes in labor legislation stimulated the growth of the union movements and, during the next decade, we witnessed a substantial increase in health insurance benefits as part of negotiated labor settlements. By the end of the 1950s, approximately 70 million individuals were covered under some type of health insurance.

However, there were two groups that were still without such support: the poor and the aged. A 1963 survey by the Social Security Administration showed that only 51 percent of older Americans had hospital insurance and 43 percent had insurance for surgical services.

A growing concern about the increasing cost of care for older persons and its potentially devastating impact on them and their families led Congress to enact

Medicare and Medicaid. This was very much in the social context of the mid-1960s, which advocated health as a right. The specific concern at the time was to provide the aged with what was then called "mainstream medicine" — that is, access to the same quality of care available to the middle-aged worker with the ability to pay. Implicit in this goal was the belief that the quality of life of older persons would be improved as they received better health care.

There is no question that since its passage in 1965, Medicare has, in fact, provided a significant degree of assistance for acute medical and surgical care to many older Americans. In recent polls undertaken by Lou Harris and Associates (for the Robert Wood Johnson Foundation), access to health care for the elderly in America seems slightly better than for the rest of the population; 93 percent of the elderly identify a regular source of medical care.

Utilization of acute hospital care increased significantly under Medicare. Total days of care in short-stay hospitals increased by 25 percent in the first year of the Medicare program alone. The number of operations for persons 65 and over more than doubled within the first 10 years of the program.

The big gap between the poor and non-poor in the use of physician services that existed prior to Medicare has been completely eliminated.

There is still relative under-utilization by minorities, but finances are probably not the most salient variable; rather maldistribution of resources remains a problem.

The relationship between Medicare's success in improving the elderly's access to health care and improved health status among the elderly has not been clearly established.

It is clear that significant gains in reducing mortality in old age have been made since the program was enacted. Whereas the death rate for men 65 and over had been rising at 0.2 percent annually for the 12 years prior to Medicare's enactment, it dropped at an annual average rate of 1.5 percent for the following 10 years, decreasing 15 percent for the decade. For men 85 and older, the improvement was even more dramatic. Between 1955 and 1967 the death rate rose by an average of almost 1 percent per year, but it dropped by over 2 percent annually between 1968 and 1978, or about 30 percent for the decade.

In terms of life expectancy at 65, between 1950 and 1960 there was an addition of 0.4 years; between 1960 and 1978, a full two years were added. Gains in life expectancy for non-whites and the poor have been greater than gains for whites, and this has been at least partially attributed to the increased utilization of Medicare-supported health care. It has been estimated that a 10 percent increase in per capita use of medical care is associated with about a 1.5 percent decrease in mortality rates. Such correlations are not proof and other public health factors including greater concern over smoking and diet cannot be overlooked.

However, the associations between the implementation of the Medicare program, higher utilization of medical services, improved biomedical technology, and lengthening lifespan cannot be dismissed cavalierly. Moreover, it is Medicare's successes in contributing to the improved access to health care, and perhaps a lengthening life expectancy, that have helped to bring us to our present dilemma.

Q Where are the courageous, dispassionate, reasonably impartial professionals going to come from — the people who will evaluate the entire national problem that you've outlined? Do we have people like that or are the cross-currents of political and professional pressures so great that this may become an insoluble problem? Or do we go bankrupt first?

A That is two questions. I will answer the first one. Hopefully some of them will come from Brown University and from the nature of the medical education provided. I alluded in my talk to the fact that we have become captivated by acute care because every one of us who went to medical school went there with one purpose in mind — to help people and to "cure" them. It makes it very difficult to be a physician if your patient persists in not being cured.

I tell you this as a personal *mea culpa*. I discovered to my horror that I could not cure a patient with diabetes. In fact, I discover now as I get older that a lot of what I do doesn't cure anybody. It helps them. It takes them out of bad situations and in many instances it makes it possible for them to live in their society and at home, rather than in an institution.

But more and more I'm discovering that my magical ability to cure is compromised.

To teach caring is tougher than to teach curing. You have to learn a different style of relating to a patient. You can't become the curer; you've got to become the consultant, the counselor and so on. It takes a different structure of medical education. It's hard to do as you bounce from one clinic to the next. Also, the reinforcements aren't there.

If you look at how payment is arranged, hi-tech procedures get precedence and cardiologists get 10 times more per minute while they are doing cardiac catheterizations than while they are counseling patients about lifestyle.

One could argue that the catheterization is enormously important, but I think talking about smoking, obesity, and stress are equally important to the longevity and to the ability of the individual to avoid a stroke and to live in the world.

Insurance companies haven't helped. It's easy to determine one person, one appendectomy. It's so many dollars. One person, one chronic disease? God. We never intended to worry about chronic illness.

The final comment is on your second question. What I think I've tried to say implicitly is there is no question in my mind that as health has become big business and as the government is paying for both state and federal about 25 percent your health care bill in the U.S. that there will be politics in health care. Interesting that private corporations pay about half of the health care bill through employment insurance. They have only begun to wake up to some of those issues and still a substantial amount of out-of-pocket money is being paid, and interestingly enough the most inarticulate group of all are the citizens who pay out of their own pocket and support the government. And so, I would accept the fact that we have allowed it to be passively political rather than a matter of public debate. I think it is unfortunate. I think that's why symposia like this are important.

Since 1965 significant changes have occurred that have placed tremendous pressure on Medicare and Medicaid. In 1965, health care expenditures were six percent of the Gross National Product; today, they account for nearly 11 percent.

Before the DRGs (diagnosis related groups) began to have their impact it was estimated that the nation's health care expenditures would increase from $322 billion in 1982 to $690 billion in 1990 and $1.9 trillion by 2000, or 14 percent of GNP. This means an average increase of $50 billion a year and a doubling of the nation's health spending every six years.

Meanwhile, costs for the Medicare program are skyrocketing. The program is now the single largest purchaser of health care in the world, having grown from a cost of $3.2 billion in 1967 to a projected $66 billion for 1985, projected to $70 billion in fiscal 1986.

In addition to escalating health care costs, we are faced with a troubled economy, a powerful political mandate to limit or reduce social expenditures, and an administration that has made defense spending its priority.

The Medicare program is in a state of crisis, due to the extraordinary growth rate of expenditures, our early failures to contain those costs, and the expectation that expenditures over the next decade will be staggering. In part, it is due to a recognition that, under our present social fabric, some elements of this growth are uncontrollable, or present us with a powerful ethical dilemma.

In 1983, it was projected that, without changes in current regulation, Medicare's Hospital Insurance Trust Fund would be depleted by 1988 and by the end of 1995 would have a rapidly growing deficit of about $300 billion. A somewhat more optimistic projection by the Congressional Budget Office suggests that, with stringent limits on in-hospital payments, the trust would remain solvent until 1992 and our accumulated deficit would reach only $93 billion by 1995.

It has been suggested that Medicare disbursements must be reduced by 32 percent, or revenue increased by about 48 percent, or some combination of the two, to bring the Hospital Insurance Trust Fund to its actuarial balance over the next 25 years. President Reagan has proposed a $19 billion cut over three years.

The matter of fiscal solvency for the Medicare program is as much a political as an economic problem. It is directly related to the larger question of how much of the GNP is legitimately devoted to health care and this is ultimately a societal focus. Of course there are no absolutes in this regard. When we were spending 8.7 percent of our GNP on health care back in 1976, the United Kingdom spent 5.6 percent, Germany 9.7 percent, and Finland 15.0 percent. Although these figures are years old, the same general spending patterns probably still hold today.

During this past year, we have seen the widespread implementation of DRG-based reimbursement. This form of reimbursement creates incentives to reduce the length of stay in hospitals and encourages the use of less expensive alternatives, such as homes or nursing homes for recuperative care to hospitalization. The experiment seems initially successful, at least according to some indicators. For example, the average length of stay for Medicare patients has dropped from 9.5 to 7.5 days this year. Daily costs will probably go up to reflect more intensive use of services in less time. However, the impact on morbidity and mortality has not been analyzed, nor is there good data on readmission rates, an obvious strategy in dealing with controlled length of stay.

The implication of DRGs for long-term-care settings are not yet clear, as is their impact upon the very old (those over 75) who comprise the fastest growing part of the aging population. Other experiments are and will take place.

> The (Medicare) program is now the single largest purchaser of health care in the world.

A major force driving Medicare costs upward is the concept of increasing enfranchisement. Law and regulation stipulate what benefits are to be publicly and privately financed. As I have indicated, this is largely a political matter, although it is necessarily influenced by economic considerations as well. By and large, it is not growing — indeed it may be contracting. This is legal enfranchisement.

The growth in the number and proportion of the aged is clearly putting upward pressure on the system. It reflects a change in the life expectancy of individuals at birth, an increase of about 25 years between the year 1900 and 1970. Equally important is the increasing life expectancy for persons 65 and over. Life expectancy at 65 increased 2.5 years between 1900 and 1970, and another two years just within the last two decades.

During a period roughly paralleling the lifetime of Medicare the number of elderly in the U.S. has increased by 55 percent, from 16.7 million in 1960 to 25.9 million in 1980. The increase for the population under 65 was only 24 percent for the same period. Those aged 75-84 increased by 65 percent, while the over-85 group grew a startling 174 percent, from under one million to 2.6 million. It is these two older groups that remain the fastest-growing part of our population.

Today, the aged comprise 11 percent of our population. By the year 2000, they will comprise more than 13 percent of the population, and by the year 2020, according to modest estimates, about 19 percent of the population. By 2040 the older population will grow to include over 67 million persons, well over 20 percent of the total population. And one final projection: within the next 100 years, the number of individuals in the United States who are over 75 will increase by 500 percent.

Whereas in the past, the age distribution of our population was almost pyramidal, with fewer survivors at each increasing age, today that pyramid is being squared off, as more individuals live to an older age. By decreasing the mortality of the oldest part of the population, we are significantly increasing the anticipated morbidity for a variety of conditions, of which dementia and hip fractures are merely two examples.

Today, some 1.5 million individuals in the U.S. have Alzheimer's disease but, by the year 2050, this number is expected to exceed eight million. The number of patients with hip fractures is projected to increase at least at least six-fold during the

same period. According to these projections, we will have many more older persons with an increased amount of both acute and chronic illness.

There is, of course, a controversy about whether increased longevity will lead to an increased period of vitality or an increase of dependency, frailty, and illness. Taking the more conservative position, there is no reason to believe that, at least for the old-old (those over 75) or certainly for those over 85, there will be any significant decrease, or even plateau, in illness.

The aging of our society bears important implications for both hospitals and nursing homes. Adults over 65 are admitted to the hospital three times as frequently as younger adults and stay about twice as long. Those over 75 use the highest proportion of services. One of five older persons is admitted to the hospital annually and, of those admitted, 25 percent are readmitted at least once.

> Within the next 100 years, the number of individuals in the United States who are over 75 will increase by 500 percent.

In 1982, 38 percent of hospital inpatient days were used by those 65 and over, who then comprised approximately 11 percent of the population. We must therefore prepare to meet the hazards of this increasing problem.

In doing so, however, we must keep in mind that the elderly are not the only group contributing to an increased potential pool of chronically disabled persons. We are now capable — with the hope of technology, superb medical care, and expenditure of billions of dollars — to keep low-birth-weight babies alive. Our success in this area raises important questions since it may yield an increase in the number of impaired children with such persistent need for expensive medical care that they qualify themselves and their parents for supplementary health care under a Medicaid-type program. As yet, we have devised no policy with regard to chronic disease for either young or old and we are paying a price for this deficiency. We will need to prepare for the clinical, ethical, and economic implications of such a policy.

Yet a further aspect of enfranchisement involves the role of technology.

We have steadily and dramatically increased the role of Federal expenditures in biomedical research. We became enraptured with the startling advances in imaging, surgical techniques, and the care of burn, trauma and heart attack victims. The miracles of microsurgery, sophisticated biological feedback systems like insulin infusion pumps, and more sophisticated feedback cardiac pacemakers all excite us. We could build an instrument to do virtually anything, even replace the human heart.

If we accept the initial enthusiastic reports from one medical center, there may even be a pump on the horizon capable of replacing part of the brain in supplying the appropriate neuro-transmitter chemical to another part of the brain — and that excites us.

This technology has had two very powerful consequences: high access and high unit cost. On one hand, there is what I call technological enfranchisement. As dramatic new interventions became possible, making them available to all who might benefit, there arose issues of social policy and, on occasion, medical ethics.

In 1983, we performed approximately 100,000 to 125,000 orthopedic surgical operations for major hip/joint replacements, something that could not have been done in 1960, and the hip replacement tale is not over. A new prosthesis has been developed this year for next year's market at double the present cost. Probably more than half of these procedures were for Medicare patients.

Much of the new technology significantly increases cost, with a marginal increase in utility.

It becomes quite clear that medical technology plays a powerful role in creating our Medicare financial crisis, especially since a social accounting of the value added to human lives remains off the books. There is good reason to believe that, since Medicare clients are on average older and sicker than the general population, virtually every advance of technology is more often applied to elderly than to the general population. While there is little question that the CT scan is an improvement in imaging over the traditional x-ray, we can more readily determine the economic consequences than the clinical. Once untreatable disorders can now be diagnosed, treated, and managed, and indeed, this is a great success, costs aside.

The aggressive promotion of any technique gives us a marginal improvement in some diagnostic capability, yet, there is no immediate way to identify the positive value to society of the increased costs that will be incurred.

On the down side, we must question whether we are really using technology appropriately. Or are we achieving a medical version of Parkinson's Law in which the number of medical procedures rises to attain a level at least equal to the rate of reimbursement, cost of amortizing the equipment, and perceived income needs of practitioners?

Our technical ability to sustain life is now a problem.

Treatment of the terminally ill poses most starkly the ethical questions of medical resource allocation. Medical ethics dictate the use of the best intervention available, regardless of the patient's age, economic status, or ability to pay.

Yet, we as a society have begun to question the large sums that are being invested in the care of the dying. As one geriatrician has put it, "At both extremes of the lifespan, the very premature infants and very elderly persons, one gambles for the long shot — investing a great deal in the attempt to save a life because sometimes it will work. Until now, we have accepted this long shot as part of medical practice. We have joined in these battles knowing full well that most of the time we would lose, but the wins made it all seem worthwhile."

A series of recent studies has determined that Medicare beneficiaries in their

last year of life use an extremely high proportion of services. This group comprised 5.2 percent of enrollment but 28.2 percent of program expenditures. Reimbursements for the last 180 days of life comprised more than one-fifth of total Medicare expenses, and reimbursements in just the last 30 days account for 8 percent of total expenditures.

The resolution of these issues are only part of the problem, for we must keep in mind that Medicare currently is meeting only a portion of the health care needs of today's elderly.

Other elements in the costing of care deserve mention. Tests and procedures including medication and surgery and the legal and insurance costs related to malpractice cannot be ignored. In short, is big business.

While Medicare assumed a substantial role in covering acute health care costs, older persons still must bear a significant proportion of these costs out of pocket.

Deductibles have increased most dramatically for hospital care. Although Medicare spends 70 percent of its funds on in-hospital stays, individual beneficiaries continue to bear significant financial responsibility for this type of care. Initially, the first $40 of hospital costs per year were covered by the individual but, by 1979, the patient was responsible for the first $60 of the hospital bill. That amount increased to $356 for each hospital stay. This year, it is $400 and in 1986 it will go to $476, based upon average daily cost of hospital care.

Moreover, these deductibles apply only for a period of 60 days after discharge. Thus, if a patient is readmitted to a hospital 61 days after discharge, another deductible charge is levied. Furthermore, deductibles increase after 60 days, and Medicare provides no coverage after 50 days of hospital care.

> Much of the new technology significantly increases cost, with a marginal increase in utility.

Costs for physician services covered under Part B of Medicare are accelerating at a faster pace than for any other major domestic program. In recent years, expenditures have increased at an annual rate of 20 percent, although this rate is expected to decline over the next few years to 12-16 percent annually.

Undoubtedly, this is the basis for the proposed policy that would require physicians to accept assignment for all Medicare patients — that is, physicians would be required to charge their patients only what Medicare pays and no more — and for the freezing of current rates for the next year. In 1983, for example, physicians billed approximately $5.6 billion in excess of Medicare levels. Of this amount, $2.5 billion were paid by the elderly personally or by co-insurance, and $3.1 billion went unpaid. Although physicians knew that much of the fees would go uncollected, they submitted these charges presumably to influence future rate structures.

In 1981, Medicare paid only 45.3 percent of the per-capita health care bill, while Medicaid paid 13.7 percent and other public programs paid about 5 percent. Private payments, including medical insurance and out-of-pocket payments, accounted for the balance, or more than one-third of health care costs for older persons. Thus, despite rapid increases in the cost of the Medicare program, the elderly still pay a substantial portion of their health care bill out-of-pocket, and spend an increasing proportion of their incomes on health care.

In 1977, elderly persons were devoting 12 percent of their annual income to health care; today, that proportion has risen to nearly 14 percent. In actual dollars, this amount translates to an average of $1,500 out-of-pocket. By 2000, this amount is expected to rise to $5,000.

Given that Medicare pays less than half the health care bill of the elderly, it is not surprising that approximately 65 percent of beneficiaries purchase private Medi-gap insurance. They spend about $8 billion a year of their personal funds, paying annual premiums of $300 to $800. And even with this investment, coverage is uneven.

Preventive measures such as outpatient drugs, eyeglasses and basic dental services are not covered by the present formula, although certain vaccinations which can be considered preventive are.

At the same time, we see a shift in the spectrum of illness among the aged that presents a new and powerful dilemma in the form of increased chronic disease and frailty. As we preserve life at all age levels there is also more enduring disability. But Medicare, like much of our overall health

care support system, was designed to provide care directed mainly at the diagnosis and treatment of acute bouts of illness. Medicare followed the lead of most health insurance which was directed at specific operations, surgical and nonsurgical alike. There is no such luck, however, with the treatment of an impaired, chronically depressed patient or a demented individual for whom procedures are ill-defined and the length of treatment relatively open-ended.

Our health care system developed primarily to meet the needs of young and middle-aged individuals with acute illnesses and disorders that could be diagnosed, treated and cured in relatively brief periods of time, and Medicare followed this model.

For the elderly, long-term assistance with home and personal care, rehabilitation, and social services can be just as critical. But these services are not reimbursed on a long-term basis under the Medicare program. Furthermore, through Medicare, we have "medicalized" the care of the aged, at the expense of other forms of care.

In the mid-1960s, the need for long-term care was not an issue of great moment. Health insurance had proved its value, and Congress clearly intended that the aged should profit from the experience of other third-party carriers. In addition, it intended to avoid dealing with the financial burden of long-term care, which was not a high priority in the early 1960s.

As a result, reimbursement for the long-term care of tuberculosis and mental illness was restricted under the program, as was nursing-home care.

Of course, tuberculosis is no longer an issue. However, the limitations in psychiatric care — both outpatient and inpatient, particularly in chronic psychiatric impairment — have created severe problems for patients and their families. In fact, the severe limitation of mental health benefits under Medicare has essentially disenfranchised millions of patients with Alzheimer's disease and other chronic mental health problems.

Let us explore for a moment what has become a crisis in long-term-care benefits under Medicare. Long-term-care institutions in the United States now house approximately 1.3 million Americans at an annual cost of approximately $30 billion last year. Medicare pays for only about 2 percent of this cost. Long-term care, which was only 1 percent of the medical bill in 1950, grew to over 8 percent by 1980, and is still growing rapidly.

Long-term care institutions in the United States are now really mediating two systems of care. *Short-term* care is defined as stays of 90 days or less and *long-term* care as stays of more than 90 days. These two groups are about of equal size — 52 percent short-term and 48 percent long-term.

Patients with short-term stays may receive some coverage under Medicare but those with stays of over 90 days rarely leave the long-term-care institutions, and have virtually no coverage apart from private funds and Medicaid.

Under its present benefit package, Medicare offers 100 days of nursing home care, with the first 20 days completely covered, and a daily co-payment equal to one-eighth the hospital deductible (about $44.50 in 1984) available for the succeeding 80 days. However, for an individual to qualify for this Medicare coverage, that person has to have been certified by his or her physician as requiring skilled nursing care. That is, the patient must need and receive daily skilled rehabilitation therapies or daily skilled nursing care to improve his condition. The "custodial" care required by many persons with chronic illnesses is specifically excluded under the program.

> Our technical ability to sustain life is now a problem.

Access to Medicare-covered nursing home care was constrained by several other factors as well. The definition of skilled nursing care has been changing over the years, and this has had significant impact on beneficiaries and providers. For example, the insertion of a Foley catheter was considered skilled nursing care in 1966, but within a few years the removal of the catheter was not. In the initial period of Medicare utilization, the program paid for a significant proportion of nursing home care, but that number rapidly fell.

Complicating this is the fact that there was a period during the late 1960s when denials for nursing home care often followed several months after the cost was actually incurred. These retroactive denials were so burdensome to nursing home officials that they became reluctant to accept Medicare patients at all until the regulations were stabilized. Nursing home officials were frustrated further by the claims requirements that became complicated and were subject to variations in interpretation, depending on the reviewer. The number of Medicare-certified beds decreased proportionately and this also served to constrain access.

Since Medicare pays so little for long-term care in the United States, who is covering the cost? The answer, of course, is that the two principal payers are the Medicaid program and the private individual, along with his or her family.

In 1982, 1-2 percent of long-term care was Medicare-supported, 54 percent was supported by Medicaid, and 43 percent was paid essentially out-of-pocket. It is important to note that because Medicaid is based on a matching formula between state and Federal treasuries, the Federal government carries a significant burden for Medicaid reimbursement through its matching grants, and pays about 25 percent of long-term-care costs.

We can also look at the problem another way from the perspective of the Medicaid program. This program, designed to cover health care for the poor, now spends 40 percent of its funds on the so-called custodial costs of long-term care.

In fact, in Fiscal Year 1983, nursing home payments comprised the largest single expenditure category under Medicaid. This substantial support of long-term care was never envisioned to be a significant claim against the Medicaid dollar, whose purpose was to cover a spectrum of illness for the needy. Today, the Medicaid program is a principal means for covering the cost of nursing home care for middle-class as well as poor elderly persons.

It is estimated that nearly half the program's outlays are for older persons who

Q I was concerned with where the resources will come from to support the climate necessary to keep mentally retarded patients in the community. If people are living longer and those in the age category that will eventually require nursing home beds are going to increase significantly faster than the other portions of our population, where will we get the resources to maintain people in a community for as long as possible?

A There are several answers. First, as I said before, there is nothing magic about 65. There are opportunities to extend employment and the support system. Maybe we should retire people for five years at age 40 or re-train everybody with a sabbatical every 10 years.

If we have one serious problem with aging in this country it is that we haven't figured out what to do with older people. I characterized this 20 years ago as the no-deposit, no-return mentality. We have never seen older people as a resource. As a consequence, we have created a third and fourth period of life in which the older person is really cut out and made to be the patient, the victim, the client, what have you. I believe we ought to draft every man, women and child at age 65 for two years of service to the community and then when they come back, they all get rewards in the form of GI benefits. They get health insurance, loans and education benefits. The wisdom of this is the wisdom of the elderly.

Second, I would absolutely contend that if we were really serious about this we would be supporting the family which wants to care for older people. Families have gotten a bad rap. There have been repeated studies that families don't surrender older people to custodial care until they're stressed and pressed. It's what I call interminable care. Long-term care gets help, minimally; short-term a lot of help, terminal care we're trying to help, but nobody helps with interminable care. I think there are social options — housing, out-reach programs.

What startled me is how, despite the fact that the Secretary of Health and Human Services and most of Congress wanted a decent hospice program, OMB shot it down by setting an impossible rate structure when the issue of social HMOs came to the docket.

Those are investments. Why in heaven's name is an investment in the MX missile more important than an investment in a social component of care which will ultimately reduce health care cost? It's your decision.

entered nursing homes as private-pay patients, but who exhaust their assets in paying for care.

Having "spent down" to a level of medical indigency, these older person becomes eligible for Medicaid. This "pauperization" of the elderly has become a compelling public policy issue.

In a recent address, Senator Daniel Patrick Moynihan proposed that fiscal solvency of the Trust could easily be assured if the administration and Congress were to make funds available from other elements of the Social Security program.

Another strategy could be linked to the changing age of retirement. Today, 20 percent of all men work past age 65. In the future, more men and women will work past 65 and be covered under employee health insurance. Theoretically, for these individuals, Medicare could serve as co-insurer, rather than primary insurer, thereby preserving Medicare's original concept — to provide coverage for the otherwise uninsured.

New initiatives on the alternate funding of long-term care in the United States are being examined at the Brookings Institution and the Institute of Medicine. Home equity, private long-term care insurance, Medicare HMOs, social HMOs and other economic or service vehicles are being examined for their applicability to cost reductions. Perhaps other funding mechanisms for professional education need to be instituted and its expense separated from cost of care.

On the human side, families provide the bulk of long-term care in the United States, but are given no financial and little professional or personal help in doing so. They are engaged in what I call interminable care. Patients and spouses become pauperized by nursing home bills of $2,000-$3,000 per month. They qualify for the financial assistance of Medicaid, but with no personal relief in sight for the spouse.

The dilemma of caring for or paying for the care of a permanently disabled individual is in itself distressing and traumatic, and doubtless induces disease in the caring family. Clearly, a national initiative is necessary to reassess our provision and cost of health care.

A change in the reimbursement formula for acute care and long-term care in both Medicare and Medicaid should be undertaken to shift our principal focus from acute hospital-based care.

The hospital long-term-care setting and hospital home-caring complex needs to be reviewed. The care of the dying and the ethical issues in life-supportive care must be openly addressed, and the role of the dying in the protection of those living clearly enunciated.

Research into cost control and alternative care strategies should be accelerated.

Alternative approaches should be provided to prevent, postpone or limit hospital care and to provide long-term continuity.

Hospice, respite, acute home care, long-term home health care, supportive housing, and other options need to be assayed. Initiatives to develop new improved technologies, and mechanisms to improve vitality and prevent deterioration must be studied and tried. Standards for co-insurance for acute and chronic care are needed.

In our immediate response to the current crisis, we must be careful, studied, and humane to all of society including our future selves, and, for our own sakes, do no harm. □

The Health Cost of Doing Business

Joseph A. Califano, Jr.

Attorney, former Secretary of Health, Education and Welfare

Joseph A. Califano, Jr., senior partner in the Washington office of Dewey, Ballantine, Bushby, Palmer and Wood, has had a long and distinguished career in law and public service.

In early 1961 Mr. Califano went to Washington as a young recruit of the Kennedy administration; he worked as General Counsel of the Department of the Army and later as the Special Assistant to the Secretary and Deputy Secretary of Defense. From 1965 to 1969 Mr. Califano was Special Assistant to President Lyndon B. Johnson. Mr. Califano had general responsibility for domestic policy and legislation and was a major architect of the "Great Society" programs in health, education and urban redevelopment.

After eight years spent in private law practice and in service to the Democratic party, Mr. Califano returned to government when President Carter appointed him Secretary of Health, Education and Welfare. He held that Cabinet post from January 1977 until August 1979. During his tenure he reorganized the department (then twenty-five years old), mounted major preventive health programs, began the collection of hundreds of millions of dollars of defaulted student loans and instituted computerized techniques to police welfare, Medicare and Medicaid programs. He also worked with Congress to restore the financial integrity of the Social Security system and to restructure federal aid to elementary, secondary and higher education, and he issued regulations to provide equal opportunity to the handicapped and the aged.

Mr. Califano's books "A Presidential Nation" and "Governing America — An Insider's Report from the White House and the Cabinet" covers his experiences in both the Johnson and the Carter administrations.

Mr. Califano returned to the private practice of law in January 1980.

In America, quality health care is like motherhood — as well it should be. It's not surprising that since World War II our national energy has concentrated on improving health care and making it universally available.

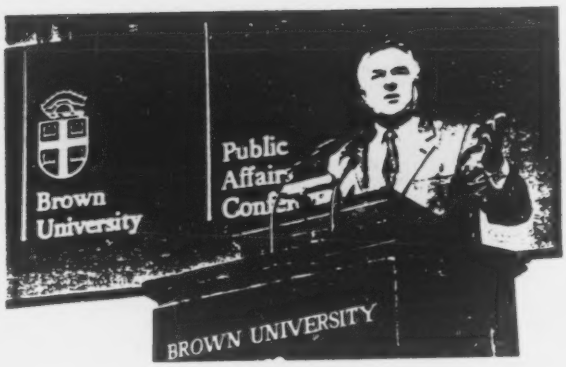
Government programs like Medicare and Medicaid, union bargaining and progressive corporate management have all been focused on more health care benefits for our people. In the past, we let costs rise, even when there was little or no correlation between higher costs and better quality health care.

For far too long, we assumed that more was better without even thinking about it. So, today in America we take more tests, use more drugs, give more x-rays, perform more surgery and spend more time in hospitals for minor medical procedures than anywhere in the world.

We lost sight of the fact that more is always costlier, even though more is not always better quality health care. We've let tomorrow take care of itself for so long that the cost of health care has become one of our nation's most serious economic, social and political problems.

Today I want to talk about these costs and how they are crippling American business, weighing down the American taxpayer, and threatening the elderly, who need health care most, with government rationing of life-essential medical procedures. I want to talk about some early hints of change, and opportunities for all of us to act.

True reductions in costs will come only with fundamental changes in the way we deliver and pay for health care. Those changes, in turn, will require action by all



the players — employers and unions, the administration and the Congress, federal, state and local government, lawyers and judges, and doctors, hospitals, laboratories, drug companies and other suppliers — and patients. Those changes should be careful and concerted, since we have a remarkable, as well as expensive, health care system.

Unfortunately, we are not getting such action. Instead, government payers are concentrating more on cutting their own costs without regard for the impact on the system as a whole. The structure of the health care industry is such that caps on payments by one purchaser produce largely illusory savings — so long as the suppliers can simply shift costs to other purchasers or to other parts of the system.

Controlling health care costs has become "The Great Health Care Shell Game." The Congress puts a cap on Medicare payments to hospitals and the hospitals can pass the costs off to the states. The states put their own caps on Medicaid hospital payments and the hospitals can move the pea to the private insurers and the "Blues."

It's time to end the shell game and fundamentally restructure the payment and delivery system.

The statistics regarding health care costs are shocking. Last year, for the first time in our history, Americans began spending more than $1 billion a day on health care.

There are some signs that actions by government and business are slowing the rise in costs. Nevertheless, health care remains the most inflationary sector in the economy.

Last year, the consumer price index went up by 4.3 percent; hospital costs went up at twice that rate — 8.6 percent. In places like Michigan, with very rich health care plans, hospital costs continued to rise by more than 10 percent, as did doctors' fees.

There is no longer much disagreement about the structural causes of inflation in the health care industry. Everyone working in the system is acting in response to the economic incentives they face. First, hospitals have generally been reimbursed on a cost, or in the case of for-profit hospitals, a cost-plus basis. Doctors are paid on a fee-for-service basis. Thus, the more hospitals have spent, the more money they have received; the more services doctors perform, the more money they receive.

In late 1983, Medicare began placing caps on the amount it would pay for 470 hospital procedures, ranging from hysterectomy to heart surgery. But even Medicare's diagnostic-related group (DRG) system is part of the Great Health Care Shell Game; it lets the hospitals shift the pea to the states and private insurers, and it lets the educators shift the pea out of the hospital and into their offices where there are no cost-containment caps.

Second — and of critical importance as we think of the potential for a competitive economy in health care — the prevailing third-party payment system eliminates any relationship between the buyer and the seller. When an American buys an automobile, he or she picks a dealer, negotiates about model, price, terms of payment, optional equipment, color, and trim. Then the buyer picks the car he or she wants and pays for it. But no one enters a hospital and says "I would like a coronary bypass today," or "I would like a hysterectomy tomorrow."

Where hospitalization is involved the patient doesn't even pick the surgeon or specialists, the family physician does. The specialist prescribes the medical procedures and picks the hospital at which they will be performed. Knowing he is not likely to be sued for conducting an extra test — and since he's not paying the bill — the doctor has every incentive to run lots of tests. So does the hospital, since its charges for tests have helped pay for the expensive equipment used to conduct them.

Because of the way the health care system is set up, Americans simply aren't aware of the cost of their own health care. Ninety-four percent of the hospital bills in America are paid by government programs, private insurers and the Blues. As a result, the real buyer of the service — the patient — rarely needs to look over the bill. And since someone else is picking up the tab, there's no incentive to comparison-shop. When is the last time a patient called around to compare prices on getting some blood tests or x-rays? Or dickered with a doctor or a hospital over a price?

Health care remains the most inflationary sector in the economy.

The structural characteristics have created a Frankenstein payment system, with gargantuan growth on the supply side as

we trained more physicians, built more hospital beds and invented more expensive medical technologies, with far too little resistance on the demand side.

The creation of this health-care-cost monster did not spring from the brain of some demented doctor. We all contributed mightily to the effort. American businesses, experiencing high growth in the post-World War II period, had little concern as they expanded health care benefits. After all, health care seemed a lot less expensive to give employees than a higher per-hour wage.

Unions demanded more health care coverage for their members, especially since health premiums were payroll and income-tax-free fringe benefits to workers. With each round of bargaining, managers who fought with other suppliers over the price of each nail or screw, and union leaders who negotiated for each half-cent an hour, kept adding health benefits to contracts without realizing that they were becoming hostages to costs beyond their control, costs that over the long run endangered jobs and hobbled profits.

The government also made its contribution. When the Medicare and Medicaid programs were instituted in the 1960s, the government was preoccupied with improving access to health care for the elderly and the poor. We paid the political price by simply superimposing those programs on the existing cost-based, fee-for-service system.

The doctors and hospitals initially resisted these government programs, but once the Congress legislated the fee-for-service, cost and cost-plus reimbursement system into them, the doctors and hospital administrators cheerfully joined in the creation of this swollen health care monster.

Lawyers, judges and juries fed this Frankenstein with malpractice litigation that established unpredictable and unrealistic standards of negligence and whopping judgments against hospitals who failed to run one test or another. And the patient wanted the best — to hell with the cost, since he wasn't paying — for himself, his parents, his spouse and, most of all, his children.

For the past two years, I have been serving as head of a special committee on health care of the Chrysler board of directors, created by chairman Lee Iacocca. This is the only committee of its kind in American business.

At Chrysler, as we fought for survival, we had to address the cost of health care. It has not been an easy task. In 1984 Chrysler's health care costs topped $400 million, making the Blues Chrysler's single largest supplier. That's more than $1 million each day. Last year Chrysler's total health care bill (which includes Chrysler's Medicare payroll tax and a portion of the health insurance premiums of its suppliers) exceeded $535 for each car we sold. That's down somewhat from $600 a car in 1983 — not so much because inflation in health care costs has abated, but because we cut utilization and because we are selling more cars. Last year Chrysler had to sell about 70,000 vehicles just to pay for its health care bills.

Excessive health care costs are eroding America's ability to compete with foreign companies. Mitsubishi Motor Corporation, a Japanese car manufacturer in which Chrysler has an investment, spends only $815 a year for an employee's health care costs while each employee pays approximately $374. Unlike Chrysler, Mitsubishi has no direct cost for retirees or their surviving spouses because of Japan's national health coverage. Chrysler's comparable cost per active employee is $5,700 — four

Q Do you either anticipate or advocate changes in the cost of medical education? How would the high cost of medical education relate to the things you've discussed today?

A When I was at HEW, I had come to believe, personally, that we should have a national health service corps. We should let medical school tuitions go through the roof, and we should provide full scholarships through the National Health Service Corps to everybody who is able to get into medical school, then require a couple of years of service from them as the only way to provide some measure of health care to people in rural and inner-city areas and prisons and places where we just can't get doctors. I think that the government is a big player in the cost of medical schools and I think the government's role now should be to reduce the number of doctors those schools are producing. I think it's achieving that goal in an almost Draconian way, now. In the Johnson years, in 1965, we were graduating about 8,000 doctors a year. We saw Medicare and Medicaid coming on the books. We said, "We've got to have more doctors to create more competition." We poured money into medical schools and the medical schools responded. They did exactly what we asked them to do. They started graduating 16,000 doctors a year, by the mid 1970s, I guess. We now realize that with the tilt of those doctors toward specialization, more doctors in the system does not mean lower costs. More doctors means more costs.

Q What concrete steps do you think can be taken to stop the enormous increase in the number of malpractice suits?

A I think we should probably adopt a system that is analogous to the Workman's Compensation system. I think that the doctors have a legitimate complaint here. If you go to an obstetrician on Long Island, you pay more for his malpractice insurance than you pay for anything else he gives you. I think it's now $80,000 a year for malpractice insurance for an obstetrician on Long Island. I think we should have a system whereby recovery is much more analogous to Workman's Compensation — as a recovery for lost wages, and not much recovery for pain and suffering.

Secondly, I think we do have to end the world in which lawyers who win these cases automatically get 30 percent of the fee.

And thirdly, 50 years ago the standard of care was local. If you went to a small hospital in a rural area, the standard of care that the doctors who operated on you were subjected to was local to that community. That's all ended now and the standard of care is essentially national, almost no matter what hospital you go to. If a physician or hospital is sued in a cancer operation situation, their standard of care is almost Sloan-Kettering's. We have to recognize that. So I think that should be changed.

hundred percent higher.

What has Chrysler gotten for its health care dollar? A health care industry that is expensive, wasteful and inefficient. Let me share with you a few examples of what we discovered as we analyzed our own health care plan in depth.

■ **Skewed values**: Among Chrysler's and the nation's elderly, a very common medical procedure is cataract surgery. The procedure takes about 20 minutes and rarely requires a general anesthetic. The average ophthalmologist charge for this procedure in the Detroit area is about $2,000. If the doctor performed three of these procedures a day, four days a week, 42 weeks a year, he would earn more than $1 million for less than 200 hours of actual surgery and have a 10-week vacation to boot. Compare this with the typical charge of $1,500 for serious abdominal surgery lasting three or more hours.

■ **Hospital and physician excesses**: We asked some doctors to investigate eight Detroit area hospitals with extraordinarily high percentages of non-surgical admissions for low-back problems. This study showed that two-thirds of the hospitalizations — approximately 85 percent of the hospital days — were inappropriate. With respect to three of the hospitals audited, none of the admissions were found to be appropriate. Had the inappropriate admissions not occurred, Chrysler would have saved approximately $1 million.

■ **Patient excesses**: Our physician experts investigated the six Detroit area hospitals with the highest number of maternity admissions for our insured. In more than 80 percent of the 618 cases studied, one or more of the hospital-days were found to be unnecessary — a total of over 1,000 inappropriate days, almost a quarter of the time spent in the hospital. If these and other maternity-related inefficiencies and excesses were eliminated, Chrysler would have saved $1 million.

Chrysler's preliminary investigation suggests that as much as 25 percent of its hospital costs may be due to waste and inefficiency. For Chrysler, elimination of those costs would have saved almost $50 million in 1984.

We have no reason to believe that Chrysler's experience is unique. Other studies have also found substantial evidence of inappropriate or unnecessary hospitalization. The Department of Health and Human Services sponsored a study of

Chrysler's preliminary investigation suggests that as much as 25 percent of its hospital costs may be due to waste and inefficiency.

the appropriateness of hospitalization of Medicare patients in 1980. The study found that 20 percent of the hospital admissions were either unnecessary or premature. Most importantly, the study concluded that 27 percent of hospital days were medically inappropriate. If we reduced the number of hospital days in 1984 by 25 percent, we would have saved more than $60 billion — without adversely affecting the quality of care.

Chrysler is not sitting still. In less than two years, we have acted to save nearly $10 million annually.

- We began a program to promote generic drugs which saves $250,000 a year.
- We mandated second medical opinions before certain elective surgeries, which saves $1 million a year.
- We instituted programs to encourage outpatient surgery, which saves $2 million a year.
- We have started a new program in Michigan to screen hospital admissions and control lengths of stay for Chrysler's non-bargaining unit employees. We project a savings of $2 million in its first year. If we could extend this program to Chrysler's United Auto Worker employees, which would require union agreement, we estimate we could save $9 million in the first year.

These steps are only the beginning. We are currently exploring several preferred provider arrangements, and are even looking at creating our own health care systems.

But Chrysler and American business can't do the job alone. They need help to restructure the financial incentives in America's health care industry to eliminate its inefficiencies and, where possible, to instill some marketplace discipline and competition, where not, some controls.

The big three auto companies spent a total of $3.6 billion for health care last year. We estimate that that's more than 31 states collected in taxes and that it exceeds the total expenditures of 18 states.

Chrysler recently introduced substantially more comprehensive optional dental benefit plans in Michigan and Indiana. The Michigan plans, for example, offer employees and retirees full coverage of all dental services through dental health maintenance organizations. There are no yearly maximums. There are no deductibles. These dental groups operate like a medical health maintenance organization. They agree to perform all dental services at a fixed, pre-negotiated cost to Chrysler.

Since these providers aren't operating on the conventional fee-for-service basis, there are built-in economic incentives for them to operate efficiently.

Some 11,000 Chrysler employees and retirees have joined these dental plans in the first open season round. Another 6,000 joined this year. They have saved themselves the co-payments and deductibles they would have paid under Chrysler's regular dental plans and avoided the risk of having to pay amounts in excess of the limits under those plans. And they will save Chrysler more than $3 million in the first year.

Clearly, the buyers — our retirees and employees — have become conscious of price and they made their own choices between two types of providers. That's how competition and common sense can work in a restructured health care system.

Sleight-of-hand tricks do not reduce health care costs; costs disappearing from the federal health care budget have a remarkable ability to reappear elsewhere in the system. Rather than reducing the cost of health care by eliminating the inefficiencies and waste in the system, the

federal government and the states have thus far found it easier to refuse to pay their share, grabbing credit for reducing budget deficits, when they are only hiding the actual health care costs under another shell. Rather than attack the structural defects in the health care financing system, the Congress and the administration have too often opted to impose a hidden tax on American business and American citizens. The federal government's "savings" are the increased costs for business and individuals.

Let me tell you what recent federal policy means to Chrysler. For its retirees, Chrysler pays for many health care services not paid by Medicare. Therefore, as Medicare seeks to ease its own financial crisis by shifting costs to the individual, if that beneficiary is a Chrysler retiree, we pick up the cost.

In 1965, a Medicare beneficiary had to pay the first $40 of a hospital stay; today, that co-payment is $400. Similarly, the daily co-payment for long-term hospital stays has risen from $10 to $100 per day (for the 60th to the 90th day of an admission). Chrysler absorbs 100 percent of these increases. The latest increases in the hospital deductible alone will cost Chrysler approximately $2 million this year. Our citizens haven't saved anything. Our government has simply hidden the pea under another shell.

> Uncle Sam will soon be playing King Solomon with your father and mother.

Some of the proposals for rescuing Medicare are outrageous examples of the Health Care Cost Shell Game. For example, the proposal by the Advisory Council on Social Security to delay Medicare eligibility from age 65 to age 67 would cost Chrysler approximately $100 million over the next five years. Over the next 10 years, the delay would cost American business and citizens some $75 billion. It would shift the cost personally to citizens not fortunate enough to have such coverage, and it would not eliminate a single dollar of waste or inefficiency in the health care system.

This nation cannot afford further delay in addressing the health care cost crisis. The graying of America is forcing the issue, with an ever-growing population demanding more expensive high-technology hospital care.

In 1940, roughly 7 percent of our population was 65 or older. Today, that proportion is about 12 percent. When the baby boom ripens into the senior boom in the first quarter of the next century, some 20 percent of our population — about 60 million Americans — will be 65 or older. And the composition of our older citizens is changing. In 1940, less than 30 percent of our senior citizens were 75 or older. By the end of this century, almost 50 percent of those over 65 will be 75 or older. It's not just that life expectancy is now 72 for a man and 78 for a woman, far more important is that those who live to be 65 now have a life expectancy of 82.

The effect of the aging of our population on health care costs is sobering. The Congressional Budget Office now projects that Medicare's hospital insurance trust fund will go bust by the early 1990s.

Yet, the hospital fund crisis is only the tip of the iceberg. Few Americans have even begun to think about the unfunded health care liabilities of our nation. As our health care costs increase and our population ages, the present, unfunded post-employment health care cost liability of the Fortune 500 American companies alone — with about 15 million employees — approaches $2 trillion. The total assets of those companies were only $1.3 trillion in 1983. That unfunded liability number alone should make us all realize that, in health care costs, we face the greatest financial and social crisis in this nation's history.

We must create an efficient health care delivery system. We can't keep going the way we are. We simply don't have the money. That stark fact presages a terrifying triage for the American people, and a debate over euthanasia more searing than our debate over abortion. In "The Painful Prescription," a book recently published by Brookings, the authors argue persuasively that, like Great Britain, we will soon ration health care in our country. We always have had rationing, of course, related to individual economic wealth. But, with Medicare the government becomes the rationer of health care for those who use and need the acute care system most. This role is reinforced by the fact that the federal government funds 90 percent of all the basic biomedical research in America and, together with state and local governments, pays most hospital bills. Bluntly put, Uncle Sam will soon be playing King Solomon with your father and mother, and mine, and with you and me.

We face a frightening specter in our nation as medical technology and spiraling costs combine to blur the lines in hospital rooms among natural death, euthanasia, suicide and murder. Without the most energetic pursuit of efficiencies, we will soon face a world in which there is no kidney dialysis for people over 55, no hip operations (or artificial hips) for those over 65, a world in which eligibility for expensive anti-cancer therapy will be based on statistical assessments of success, and key organ transplants will be severely limited to special cases of virtually certain recovery — all as defined in pages and pages of government regulations.

What kind of a vision for the future is that? It's not a very pleasant one. But in Great Britain that future is now. That's just what they do today. We in America are fortunate because we still have time to avoid that fate. We can learn from Britain's experience. We have a far more productive society. We can well afford to provide quality medical care to all, but we must have a coherent national health policy which will eliminate inefficiencies and reduce the cost of health care for our society as a whole. These issues, which go to the very sanctity of human life, are what add a special dimension and solemn responsibility to those who work in the health care industry and make it such a privilege for me to speak to you for a few moments.

The Proper Role of Government

David Durenberger

Republican Senator from Minnesota; Chairman, Health Subcommittee, Senate Finance Committee

David Durenberger came to the Senate in 1978, when he was elected to serve the remaining four years of the term to which Hubert H. Humphrey was elected in 1976. Senator Durenberger was re-elected in 1982, the first Republican from Minnesota in thirty years to be re-elected to the Senate.

Prior to 1978 David Durenberger practiced law and served as chief of staff for Minnesota Governor Harold LeVander (1967-71).

As Senator, David Durenberger serves on five committees: Finance; Governmental Affairs; Environment and Public Works; Select Committee on Intelligence and Select Committee on Ethics. Within the Senate Finance Committee, Senator Durenberger chairs the Subcommittee on Health which includes in its jurisdiction the $80 billion Medicare and Medicaid programs.

Senator Durenberger is also an active member of the Finance Committee Subcommittee on Social Security and Income Maintenance Programs.

This conference has a great set of objectives: How do we increase access, insure quality, benefit from and manage new technology, and stay within our financial means; preserve our quality of life and guarantee the right to a minimum level of quality health care for all Americans? Terrific agenda, and that's a good statement of the quandry facing the American public today.

You've heard lectures on costs. You know that the health care system in the country, principally the *sick* care system, the one that runs hospitals, doctors, and other "pain" killers, is a billion-dollar-a-day system. It has reached the point where it takes money away from *health* care and commits it to *sick* care, and at that point it itself becomes enough of a pain in our society, so that we have decided to do something about it. There are among the speakers here, people who will talk to you about the causes of the problem. I will simply dismiss that by saying "cause" is the same "cause" that has farmers going bankrupt in the middle west — that has the average cost of housing in America somewhere up in the neighborhood of $96,000 per three-bedroom home.

And the cause is "having" — H-A-V-I-N-G — our desire to "have" today and send the bill off to someone else. It is a gift to my generation, from my parents who conceived and brought me into this world during the Depression, and it's their way of making sure I never have to live through what they lived through.

So, in the post-world-war period, they created consumption — created easy money. They took the cost, the price tag off of everything, so I wouldn't have to worry about that sort of thing, and they did it all in the name of accessibility. I should have a three- or four-bedroom home with a fireplace — at least in this part of the country; in my part of the country, a recreation room and a two-car garage and three cars parked in front of it. I should be able to recycle those cars once every three years so I never go without "having" the latest.

The cause of the high cost of health care in this country is that we decided to do the same thing in the health care area.

I'm going to talk about Joe Califano and his employer, the Chrysler company, and I'm going to talk about Lee Iacocca, the president of Chrysler, in one minute. Chrysler — American business in general — has taken this notion of "having" today, built it into the health care insurance system, destroyed the health insurance system, gave the country a billion-dollar-a-day headache, and now they're sitting around complaining about the fact that government doesn't do this, that, or the other thing.

My mother, who is 73 now, has already sent me a living will. She has concluded that there isn't enough money to go around, so she doesn't want to be a burden. The American Medical Association is drafting "quality of life" criteria by which to assess the value of bringing certain low-birth-weight children into the world, and maintaining them in this world — particularly if they're handicapped in some way.

I went to campaign in South Dakota and I was in a hospital there, run by Benedictine nuns. After I'd made my presentation, a doctor in the back of the room said, "You know, half the people I treat are dead. They're alive, but they're dead. They're comatose. And I'm wasting all this money keeping them alive. I wish you'd pass a law saying that I didn't have to do that."

And I said, "Doctor, please don't ask *me* to legislate when life begins or when it ends."

We are dealing with life-or-death issues today — in the context that there isn't enough money to go around to satisfy everyone, so maybe certain babies should not be permitted to come into this $4,000-a-day world in an intensive care unit, in a neo-natal unit. And/or my mother ought to get out ... at some point. That's the problem. I don't think it has a legislative solution because there's so many inefficiencies in the system. There's no need for my mother to die early, and there's *absolutely* no need for society to deny access to the life that you and I have to children who are unfortunate enough to have been born at two pounds or two and a half pounds because this society couldn't spend enough to educate a poor, black mother on the disadvantage of smoking and drinking and a whole lot of other things. We didn't have a few measly nickels to help that woman out, but we had $205,000 to help a doctor or dentist from Washington state get an artificial heart that extended his life for four months. That's what's wrong with this society.

Access deficiencies. Is the problem of access to health care for some people in our society growing? Of course it is. It's a symptom of the cost allocation problem — the notion that we are a society of limited resources. And it's the knowledge that we are taking from prevention to feed this very expensive $1,000-a-day — whatever it is, in the hospital — acute-care system.

Are there more poor, or medically indigent, or people without insurance, in America today than there were when Ronald Reagan became President? Of course there are, but that's not the most serious problem. The more serious problem is that they are much sicker than they were when Ronald Reagan became President of the United States. It takes a long time for some people to get up the nerve to go into an emergency room, and it's only after they're dying that they go.

> Maybe certain babies should not be permitted to come into this $4,000-a-day world in an intensive care unit.

Someone brings them back to life and has to deal with their living environment, if they're living in some flop house, without anything to eat, without anything but booze to drink. The poor are pathologically sicker today when they finally do get into one of those very expensive, $1,000-a-day hospitals. Yet, we don't recognize that at the national level.

Our elderly in this country are impoverishing themselves, which is not bad for my generation because they're downshifting their assets to me — to my generation, I guess. But they're impoverishing themselves, just to get into a health care system that we are using to provide social services like housing and food for them.

There are two problems I had with your agenda. One was Joe Califano. The other is Ted Marmor. I don't think that's a great problem; it's just that it gives me an opportunity to say that *they* and 3,170 Minnesotans were the only people that didn't

Q Senator, I noticed with interest your comment about leveling the playing field between the proprietaries and the nonprofits and recognizing that the proprietaries still are getting a return on equity, which the nonprofits are not. I wonder if you'd comment further on that, on what seems to us in the nonprofit sector to be an inequity.

A Why do we maintain the distinction between for-profit and not-for-profit? That is a societal question that I expect we will deal with, with greater frequency — whether it's in health care or in education. If (Secretary of Education) Bill Bennett and some of those people have their way, a lot of private schools in this country are going to be in trouble.

On the hospital side, there are two sides of it that I would share with you. The greatest advantage that the investor-owned has currently over the nonprofits or the public is their access to equity capital. They can go on the New York Stock Exchange or the American Exchange or the over-the-counter market or whatever. If they've got a good product, that's the way they bring in their money. When all things are equal, that is a whale of an advantage that nonprofits don't have.

The second advantage that they have is vertical integration. They, more quickly than the nonprofits, are building themselves into insurance companies. Charity can't keep up with all of this.

Patient services will pay your hospital. Hopefully, the poor will be financed from taxes, as will Medicare and a variety of other services, but patient services will pay the bill. So the person who gets to the patient and sells him a plan and can then lead him by the hand to a hospital or doctor has a lot of leverage.

The second question I raised with the nonprofits was this. Where are you going to be when 7,000 American hospitals become 30 health plans, competing with each other, and you're just down there running a hospital? Tax laws, in particular, have an effect on how all of this comes about. One of the big issues in tax reform that goes way past flat-rate taxes and simplicity is what happens to the playing field in public service areas, whether it's in health, or education, or transportation, or a lot of other things. Are we going to for-profitize this country? Is that where we're headed? And what is the role of charities, foundations, philanthropy, and so forth?

really understand why Ronald Reagan ought to be president of the United States for another four years.

As you know, Joe was a health advisor to Presidents Carter and Iacocca. And Ted was a health policy advisor to some lawyer by the name of Mondale. It'll be interesting and I'm sure it was interesting last night to listen to the advice that they used to give to presidents or presidential candidates. They may never have the opportunity to give again because of one election, one *incredible* election.

We had one like it in '76 when Jerry Ford got thrown out of office by a governor from Georgia, who promised very simply to balance the budget. He said this country has to live within its means. There are too many people spending, spending, spending and taxing, taxing, taxing. We have to learn to live within our means. Jimmy Carter became President of the United States on the theory that he was going to force us to do things better and differently, and he was going to balance the budget.

Nineteen seventy-seven. Next year. A couple of old geezers in California came up with something called Proposition 13 and they said, "Look, in California state government, we're wasting money. We're spending, spending, spending and taxing, taxing, taxing and it's all being wasted. Tell you what we'll do. We'll turn off the tax part, and that'll get them to spend better." And it passed.

Nineteen seventy-eight in the state of Minnesota. Two Republicans, neither of whom had ever been elected before, were elected to the U.S. Senate in a state that had produced, in the previous 30 years, Hubert Humphrey, Walter Mondale, and Eugene McCarthy.

Nineteen seventy-nine. One of your neighbors had something called Proposition 24, which was much the same as Proposition 13.

In 1980, a 70-year-old movie actor and General Electric salesman became President of the United States. All this was done on the premise that government costs too much, produces too little, and the way to shut it down is to cut off its water and force it to balance the budget. So, in 1981 we did the things the American public told us to do. We cut spending and taxes to a fare-thee-well.

In 1984, the election proved that that's what we had to do. We had to balance the budget by cutting spending and t[illegible]

Now, I doubt that there's anybody who believes that that's what's going on in this country. However, except for 3,170 people like you in Minnesota, everybody bought in: the biggest election victory in the history of the country. Biggest election victory ever.

The President was given a blank check to balance the budget in whatever way he thought possible. He won the battle over who can cut deficits. Despite his record he won the battle, and the battle was: Who's most likely to turn this government around? Who's most likely to balance the budget? Mondale and Carter had taken the national debt from something like $600 billion up to $715 billion in four years. That was a 20 percent increase in the federal debt in their four years. And out they went.

Ronald Reagan took it from $715 billion to, this year, $1.5 trillion, and we knew it when we voted for him. He more than doubled it. And we elected him because we had the faith that he could find the solution to the problem and the other guy couldn't, because we just felt better, and more optimistic that he would find the solutions. So now he and we, the Republicans and the United States Senate, are faced with finding the solution. I think about our situation in much the way as the old joke, "Why were there so many heroes at the Alamo?" "Because there was no back door."

Some of you who are into politics know that your senator and your congressman or congresswoman send you these letters, telling you that if *they* were in charge, things would not be the way they are. It's that Congress that creates all those problems. If they were to have their way, things would not be that bad.

We've created for ourselves in the Congress an Alamo that always has a back door. I mean, we're being shot at by everyone in the country. Proposition 13. 24. Cut spending. Cut taxes. Deregulate. Do this, that and the other thing.

Everyone is out there beating on us and we always have the back door that I can get out of. Now, 535 people can't get out of it at the same time, but I can. Enough to get myself reelected. And 535 people do that. So you'd think that 535 people would spend their time going out the front door. If all those mad people are out there saying, "You've got to get the cost of health care down, you've got to do this, that and the other thing," you'd think we'd find a way to get out there, instead of continuing to run out the back door.

The reality is, that for us, there are 535 front doors. Everyone of us has a budget-balancing plan, at least everybody who was up for reelection in 1984. Everybody had a plan for balancing the budget, but no two plans were the same: i.e., 535 different ways to go out there and face Pancho Villa, or whoever it was, who was shooting us up.

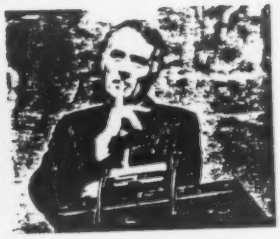
That was our problem until November 6, 1984, because on that date we put President Reagan in charge. The American public said: "Those idiots aren't going to find a way out the front door of the Alamo. *You* find it. We trust you."

We are waiting for the General to tell us which door to go out of. The General believes in balancing the budget, we all know that. He ran on it in 1980. In the State of the Union message he said we should pass a constitutional amendment to balance the budget, which must mean that he wants us to balance the budget.

But what has he produced in the way of a design for balancing the budget? He has given us a deficit of $144 billion in 1988, when he leaves office. Under the most optimistic of his own scenarios, that deficit goes down in the 1990s to something like $80 billion a year. . . Now that's his design for the front door.

> The first problem is acknowledging that health, like education, is a national responsibility.

And we said, "Hey, General, we've tried that one before. We've tried deficit spending and debt and all that sort of



thing. It doesn't work. They won't believe us out there. They'll shoot us."

So, we all went to the back of the Alamo in January and we had a meeting. 53 of us sat in Blair House, and we got up our courage as Republicans and we said, "We're going to design a way to get out the front door. We're going to balance the budget by 1990." The next day, we had to start trying to figure out how to do it.

I tell you all this because you cannot talk about the future of health policy or government's role in it without putting it in a time context. Ladies and gentlemen, that's real time context that I have just described to you. Ronald Reagan may believe in a balanced budget, but in the near term he believes *more* in deficit.

Defense spending was $134 billion in outlays in 1980. This year, it's $254 billion, and by fiscal 1986, it will have doubled in six years what it took us 200 years to get to.

Social Security, Medicare, Civil Service Retirement, Military Pensions were $199 billion in 1980; this year it's $322 billion. Interest on the national debt in 1980 was $53 billion; this year, $130 billion. That ought to start bothering you one of these days. I know that's too big a figure to think that you're responsible for, but I'm having it easy today and sending you the bill, and the bill is getting bigger and bigger every year. It was $53 billion per year in 1980, and five years later, it's $130 billion a year. By the end of this decade, it'll be $200 billion a year. Just interest on debt — it doesn't buy a thing. It doesn't get you one first-cent of a Pell Grant. Just pays off your father's T-bills, or your mother's IRA, or something like that.

Those are the areas that we can't do anything about. We can't cut defense. We can't cut Social Security and pensions. We have to pay interest rates. But, we're going to go after the rest of the federal budget which, in 1980, was $190 billion; 1981, $198 billion; 1982, $197 billion; 1983, $211 billion; 1984, $203 billion.

That has a consequence for us as we tackle the battle of reforming health care. The first problem is acknowledging that health, like education, is a national responsibility. Yes, it may be conducted in hospitals in small towns, but it is a national responsibility. Yes, it may be conducted in small colleges across this country or in little high schools, but I think it is a national responsibility. There are a lot people who don't agree with that.

Our problem is that we refuse, in the town where sound travels so much faster than light, to address the topic that has been assigned to me this afternoon: the proper role of government in our society.

I've suggested that some people are using the deficit to eliminate a lot of functions of the national government. And to the degree that the President is doing that, it's because he believes that he will hand off to a future generation a lot less expensive government than the one we have today — that even though we are sending a bill of $28 for every dollar that we "have" today, that young people are going to be better off for the fact that we've gotten the federal government out of a whole lot of things that it had no business being in, in the first place.

There are those who use the deficit to keep the Congress from ever coming up with anything new. After all, every time there's a problem, we've invented a program, haven't we? The one good function of a large deficit hanging over the country is to make sure we *don't* try to solve any new programs like acid rain.

I have a bill that doesn't spend government money directly on eliminating acid rain. It's an emissions tax. Somebody wants to pollute; they *pay* to send that stuff up. The money is used to attack the pollution. But Dave Stockman said that plan costs $6,000 per fish; so we can't have it.

I have a bill that would cost $58 million to change the Medicaid program so that state Medicaid administrators could provide health education instruction for poor women who are pregnant. Right now, if they provide it for poor women who are pregnant, they have to provide it for everybody who's poor and I'd like to change the law so it says you do it just for poor, pregnant mothers. It costs $58 million to do that; it would probably save a quarter of a billion dollars, but we can't factor the quarter-billion into our deficit reduction. So it costs $58 million and my bill isn't going to go anywhere.

> Ronald Reagan may believe in a balanced budget, but in the near term he believes more in deficit.

One-half of the people in America get their drinking water from underground and as all of you know, whether you live in this part of the country, or Florida, or in my part of the country with its so-called wonderful lakes, we are facing a crisis in toxic pollution of our groundwater and our drinking water. But there's no money

to spend when you have a deficit of $230 billion a year.

One of the problems with a philosophy of consumer choice in health care — this reform that we're all involved in that's premised on consumer choice of competitive health plans — is that the key to consumer choice is a marketplace. The key to a marketplace is that you put a price or a cost on good and evil. At a time when you have a large deficit, putting a price on anything is very, very dangerous.

What do I mean when I say that this consumer choice marketplace depends on putting a price on good and evil? I told you Barney Clark smoked 2½ packs of cigarettes a day for 25 years, went to the University of Utah, got an artificial heart, lived four months, and his widow sent a bill to Medicare for $205,000.

Now there is a price on smoking. It says that you can have an artificial heart and still smoke 2½ packs a day for 25 years. That's a price.

I could go into chemical dependency; I could go into people who ride motorcycles without helmets, or a variety of other things.

Lifestyle premiums on life insurance and health insurance would put a price on smoking and drinking and a lot of other things, but the insurance industry has a hard time coming to grips with all of this because their agents want to peddle insurance — and they don't really want to deal with our lifestyle problems.

The "prospective payment" system that we've developed for Medicare puts a price on going into the hospital. The old cost-based reimbursement system didn't cost a patient anything to go to the hospital because somebody else paid the bill and, whatever the hospital and the doctor wanted to charge, they charged and the third-party payer paid it. Prospective payment says we should only pay X number of dollars for each of 468 categories of hospital admission, and it's based on a national average of experience we've had in that area, all of which is over-priced, I'm sure.

You should hear people complain about that. Holy Cow! But I'll tell you what they're complaining about. I spoke to the Out-patients Ophthalmic Surgery Society in Dallas, and in the Q&A section a fellow with a United Kingdom accent, said, "Why is it that ophthalmic surgeons in Australia get only $140 for cataract surgery, whereas in the United States, they get $1,500?" I said it's called, "Having!" We have to *have* all these things without putting a price on them. So the doctors put the price on it for us. An ophthalmologist is worth X hundreds of thousands of dollars, and they all know that when they go to medical school and decide which specialty they're going into. There's no price competition in that business, except from the optometrists and some of those people.

Pricing. In the current and in the future, people will pay for what they get, and that's it. The healthy will insist on being rewarded for staying healthy. And the group rating system which insists that the healthy pay for the sick — and the young pay for the old — is kind of shaky.

Barney Clark smoked 2 1/2 packs of cigarettes a day for 25 years, went to the University of Utah, got an artificial heart, lived four months, and his widow sent a bill to Medicare for $205,000.

The current insurance system in which we all pay for the poor and the uncompensated is a little shaky.

The current system in which which we all pay for the surplus of doctors in this country, and the surplus of education that they get, and the surplus of income they get is very shaky.

Why can't this society deal explicitly with the issue of medical education? Why does it have to hide the bill in my insurance premium, where I can't see it, and nobody else can see it, and we have 50,000 more doctors than we need? Society insists on dealing with these issues explicitly — by putting a price on it.

It doesn't mean we don't want medical education. It doesn't mean we don't want to deal with the poor. It's just that if you hide the poor in a public hospital, if you hide the poor in the uncompensated-care column of every other hospital, in a competitive environment where you are trying to hold the prices down with choice and competition, whoever happens to be located downtown where the poor live is going to go out of business. It isn't just that the for-profit or the investor-owned hospitals will come and build in the suburbs where the people who can pay, live — that isn't the only reason. It's the fact that Charlie and Will Mayo, when they created the Mayo clinic, told the clinic it has to take everyone who wants to come.

When the Sisters of Charity, or the Sisters of anything in this country, take their vows, after they get past the vows of chastity and obedience, they have to take a vow of poverty — not only personal poverty but a ministry to the poor. They have hospitals all over this country, in very tough areas, and they have a lot of poor people, and they have a tough time holding down those costs.

I need to finish on the point of subsidies. There're three ways to get something for nothing. One of them is to have the government pass a bill to give it to you, and that's the one Ronald Reagan's working very hard on. Anything I spend is rotten money — or burning money, as he called it. I waste a lot when I'm spending it directly, because I'm the politician and we're all bad.

The *Wall Street Journal* is a great place to find examples of how awful I am. In early December when they took a blast at government spending the first time, there was a very interesting advertisement. It was a quarter-page advertisement for single-engine Cessna aircraft. It said "Two reasons why you should buy Cessna single-engine aircraft." I never got to the second reason because the first one was, "Because the IRS will give you all your money back."

Pretty good, huh? You struggle to get some operating funds for mass transit in some big city — that's direct spending.

But you can "have" a single-engine Cessna airplane and the government — your fellow taxpayers — will pay for it.

Now that's the second way. Get inside the Senate Finance Committee, of which I am a member, and lobby yourself a tax expenditure, which today totals $327 billion — in private spending. While we're capping Pell Grants and student loans and food stamps, the corporate lunch still gets written off.

There's a the third way — and this gets me to Lee Iacocca — that's the greatest scam of all. It's called "keep the competition out." In Maryland and Massachusetts and New York and New Jersey it's called "state rate setting." You sort of franchise the hospital system and that way you can continue to subsidize the poor, and the high-priced labor they have in their hospitals, and the high-priced doctors and the overuse of specialties. They're ripping the rest of us off in this country, but they use "keep the competition out — certificate of need," as a way to prevent it from happening.

> You're paying $3,000-per-car more today than you had to pay so they could keep those $25-an-hour jobs in Detroit.

In automobiles, they discovered the same thing. It's called "keep the Japanese out." You all know there was a day when "Made in Japan" meant inferior quality. The problem today is that the reverse has come to be true, at least in the automobile industry. Americans would like to buy Japanese cars and if they do that Detroit is in trouble at $25 an hour for every United Auto Worker and a million dollars a year for each president of an automobile company.

What do you do? You keep the Japanese out. Just keeping the Japanese out isn't enough, though. You have to convince the American public that they ought to pay the difference between what they would have paid for a Japanese car and an American car.

You can accomplish that in a couple of ways — by letting the Japanese bring in more expensive cars, which they have done. The net result of it all is that *you* have been taxed $15.7 billion over the last three years so Iacocca could write that book. To make himself look good, he sent me a check for $500. I used to own a Chrysler, so I got a check for $500 that I can use to buy another Chrysler. Today, Ford is sending checks of $2,000 to all their employees.

Who's paying for it? You are. You're paying $3,000-per-car more today than you had to pay so they could keep those $25-an-hour jobs in Detroit — all subsidized by you.

I don't know what Joe (Califano) said when he was here about their health program, but that's the greatest rip-off in the world. You are paying $2,700 a year in your taxes so they can have $6,000 a year worth of health insurance — so he can stand here and make speeches about how it adds $535 to a cost of a car.

The average worker in America has a health plan that would add $178 to a price of a car. But at Chrysler, General Motors and Ford, it adds $535, and the difference is how they have ripped this country off, with their golden handcuffs, and their first-dollar coverage, their destruction of health insurance. *They* have given this country "the billion-dollar headache."

So, when business and industry is ready to come to grips with that issue — go past second-surgical opinions and all that sort of thing, start giving employees a choice of health plans; break that first-dollar coverage; get people to cost-share; give them a choice of plans; get them to buy more or less, as the case may be; get the employees involved in making those decisions — when that spreads across this country, when you break the yoke that the steelworkers and the auto workers have on those industries — then you'll be able to do something about the high cost of health.

Those are three ways that the system gets subsidized. We have to foster consumer choice with information, quality assurance (that's an important role of government), income-tax preferences for choice of health plan, a level playing-field in financing health care (we shouldn't distort it in favor of for-profit and against others), and a flat tax reform.

In the flat-tax effort, you're going to see another role of government — taking us away from our dependence on the income tax and shifting it more to consumption.

Lifestyle — I've talked about how important it is that we put a price on bad lifestyle, just so there's a little reward for those of you who practice good lifestyle.

In the area of Medicare re-structuring, we're moving from a Medicare insurance plan to competitive medical plans, where the elderly and disabled will have a choice of health plans. We're trying to move the disabled — and I thank Rhode Island and John Chafee for his sensitivity — trying to move the disabled out of the welfare system and to the Medicare system, which is part of our social insurance system. There is no reason why profoundly retarded children should be treated as welfare cases in a society like this.

We ought to means-test the Medicare program. Claude Pepper gets his Medicare almost for nothing, and he makes a million dollars a year. He can afford to pay something. He's already getting his social security for free.

And the indigent? There is a problem for the Republican Party that we need to learn to deal with.

One thing we don't need is regulation. We don't need rate regulation — we don't need to maintain the cross-subsidies. We don't need to have different reimbursement systems for each particular mode in this area.

There is so much going on today, and it's in there someplace that you all are going to have to slow down the volume of the transfer of sound, and increase the transfer of light.

Q Senator, a question about training programs for physicians. Family physicians and primary care physicians have been shown repeatedly to provide a rational, low-cost approach to medical care, with low use of hospitals and ancillary services. Due to their very nature, though, hospitals don't find training such physicians to be very cost-effective. Residents don't support surgical services, and they spend a lot of time in unreimbursed or poorly-reimbursed ambulatory activities. In recognition of the lack of such hospital incentives, Health and Human Services over the last 10 years has provided support for training of family physicians and primary-care residents. This has been targeted for elimination by Reagan, and this, in combination with the decrease in Medicare support for residency-training proposed in recent legislative initiatives, may result in a real double-whammy where primary-care training grants could be severely cut. This would worsen the mound distribution of physicians, forcing more into the highly lucrative specialty areas. Is there a role for government and do you see any legislative initiatives to protect such training?

A If you step back 30 years when industry made the commitment through the golden handcuff process to make health care a free commodity in this country, they should have known how supply and demand works. When you tell everybody it doesn't cost anything, the demand goes way up. The supply always struggles along, behind the demand, but obviously the supply can raise its prices beyond true cost. So, in this country, up until recent years demand has always exceeded the supply.

Fifteen years ago, we made a national commitment to get more medical doctors in this country, and we went to capitation — which meant the federal and state governments paid people to go to medical school. We did that for six or eight years, then we got a report that said we were going to have 50,000-too-many doctors, if we weren't careful. So we quit it.

At, or about that same time, we said the real need was for primary-care physicians, particularly in rural communities and small towns and so forth. So we started a program to have primary-care physicians. That's what we've been doing. We are always five years behind the time and we quit five years too late in Washington.

Consumer choice in health care provides me with an opportunity to put my health in the hands of a primary-care physician because I need that primary-care physician to decide whether or not I really need this specialty, that specialty, or whatever. Today I am encouraged by the no-cost system, which says, "Why not the best? Why not go to the Mayo clinic — or to something famous around here? Do you have to go to Boston? No.

I need you — if you're a primary-care physician in this new environment.

The whole re-structuring that's going on — into medical groups, into pre-paid plans like HMOs — all of that is premised on somebody being my medical gate-keeper.

So I would say to you that the primary-care physician is going to be the most important person in this process. He must select the specialist for me. He or she will make the decision for me, as to whether I should be hospitalized and if so what hospital. He or she will make the decision for me relative to skilled nursing facilities, home health, hospice, some of these things.

So I think the way the economics should work in this system is that we won't have to create programs to encourage people. The economics of it is going to dictate that people abandon their hopes of some particular specialty, if there is a surplus in that area, and that they turn to general medicine.

Q It is my observation that in dealing with dental health care, the dentist often finds himself in the same bag as the physician, whereas the inflation rates over the last 15 years show that dentistry has been fairly competitive — in fact, a little below inflation. Juld your comments be the same or would you have something else to say to the dentists?

A I'm just like everybody else. I'm non-expert, and I live off my own real-life experiences, and it seems to me that it was the dentists, not the doctors, who first taught me about prevention. It was dentists, not doctors, who went into communities to stop cavities with fluoridation. It was the dentists who first explained to me, "Well, this is what I see in your mouth, and here are your options, and here's what it's going to cost." They talked to me about the economics. I've never had a doctor talk to me about the economics.

So, the reality is, that it is in the dental profession that we have seen the kinds of accents on health as opposed to the remedial side. In large part, because of a surplus of people in that profession, and because they've been so good to us that we don't have cavities anymore, the net costs have risen almost not at all. So now the dentists are getting lumped together in the sense that as people cut back their purchases, they might be tempted to take the dentists out. I know that bothers the dental profession a great deal. For some reason it doesn't bother me a lot because that's the kind of thing I'd like to see in my health plan. I think a lot of people would. They would be willing to pay more of it themselves, but they'd like to see it in the plan.

An even worse problem is when we get to mental health and chemical dependency. Here we, as a society, have some doubts about what we're getting for our money. At least when I come to a dentist, the pain goes away or the cavity goes away or the bridge is built or something happens to me. I can see it when I write out my check.

It is less clear in psychiatry and in some of those areas what we're getting for our money. It is in those areas that those of us who believe in wellness and comprehensive health care are concerned that we not lose out by putting all of our money into hospitals and doctors. The responsibility for that, in Medicare, is the government's. In every other place it's the negotiation between the employer and the employee to insist that when they have a choice of health plans, that in each health plan be a basic dental benefit, in each health plan be a basic mental-health benefit. They can add to it, take away from it with cost-sharing, but the benefit ought to be built into the plan so that I can see what the HMO will do for me in mental health or dentistry, versus what Blue Cross or somebody else will do. I want to see it in my annual choice of health plan.

A Sampling of Alternative Health Providers

Panel: Richard Knox, moderator; Winfield C. Dunn; Daniel C. Burnes; Jacob Getson

Richard Knox

Medical Writer, *The Boston Globe*

Richard Knox has written for The Boston Globe *since 1969, most recently on medical and health issues. A graduate of Columbia University Graduate School of Journalism, Mr. Knox did his undergraduate work in English and history at the University of Illinois. He is the recipient of a number of awards for his reporting including a national award from the American Heart Association. In 1978-1979 Mr. Knox studied at Stanford University on a National Endowment for the Humanities Fellowship. A continuing topic of interest to him is the impact of new medical technologies.*

Knox: Our topic this afternoon is a necessarily ambiguous one: alternative health providers. That doesn't mean the holistic health crowd. It encompasses a broad waterfront, though, as our three speakers demonstrate. We have here the director of a new organization that hopes to dot the landscape with profit-making prepaid health plans. We have the manager of a controversial new set of initiatives by Massachusetts Blue Cross and Blue Shield to market and operate various kinds of managed care systems and reimbursements. And we have an executive of the nation's largest investor-owned hospital chain.

As diverse as these presenters are, they really represent only a fraction of what's currently going on. It sometimes seems to me that every week brings some new variant on the alternative front. Moreover, this fast-evolving picture is complicated by the fact that many of the alternative providers are, in fact, traditional providers attempting to remake themselves in order to keep up with the perceived market threat from the new guy down the block.

Hospitals are becoming HMOs (health maintenance organizations), and HMOs are acquiring hospitals. Conglomerates are acquiring or attempting to acquire old-line teaching hospitals and even entire medical schools. The Humana Institute is conspicuously pursuing, for example, its own strategy to establish itself in the front ranks of American medical institutions.

Insurers are becoming direct providers. Doctors, perhaps in response to the changing market for their services, are increasingly willing to hire themselves out to companies over which they have little control and to work in settings such as the aggressively-marketed walk-in centers that are springing up like fast-food joints.

We all know that something important is happening, and that it is altering profoundly the way millions of Americans get care. The relationships they have, or fail to have, with the people in institutions in which they entrust their medical care and a substantial portion of their annual incomes affects the consumer's sense of the control and accountability that will exist in these new configurations. And it affects the type and amount of care that is made available to enrollees, and the setting and many, many other issues that have yet to be examined seriously.

I would submit that we really don't know what will come of all this, much less whether we will really like it. We — that is, the public for whom people in my position are surrogates — really don't have much influence over these trends, either.

Paul Starr makes a persuasive case in his book "The Social Transformation of American Medicine" that the phenomenon should be viewed as the corporatization of medicine, and that it is a predictable outgrowth of the failure of American doctors to maintain sovereignty — as he calls it — over their profession. One of my worries as a journalist who tries to cover health-care issues is that it will become more and more difficult to find out what many of these institutions are up to, who they are actually serving, what their track records are — not that it is a snap to learn these things from the traditional providers.

New England is a very interesting place to observe and discuss these trends. We are behind many other regions in the degree to which many types of non-traditional health providers are already integrated into our landscape. The reasons are complex and undoubtedly fascinating, but they have not been well articulated. As a Midwesterner who came to Boston as a naive medical reporter almost 16 years ago, I began to realize over the years that the region is characterized by distinctive sets of values that often find expression in our leading institutions, especially educational and medical ones. People inside these institutions and within our communities often seem rather oblivious to these values and how they affect their behavior. Indeed, I am hard put myself to delineate them. I just know that we are a little different here in the way we look at health care institutions, at their privileges and obligations in the community.

Undoubtedly, this is historical in origin. Our institutions, at least the flagships on which many community hospitals are modeled, tend to be very old. They engender and embody the best philanthropic motives in their respective communities. People identify strongly with them in many ways.

There may also be something deeper in the New England character related to puritanical or Calvinist concepts of one's duties in this world to which traditional medical institutions appeal. Is this attitude or set of attitudes passe? Is it dysfunctional? Is it silly even to be nostalgic, as some clearly are, about the displacement of the models by others that are really based on the corporate models and remote managers? For that matter, have the institutional models that some yearn to keep already passed from the scene in any recognizable form?

I don't think we really know the answers yet, and I think we ought to try to identify what it is we value and would like to keep or build into the emerging health care institutions, and what is really not worth mourning.

Whether we like it or not, I think these questions are the backdrop for any discussions about the current and future scene. Let me introduce the first of our distinguished panelists, and let them tell you what is happening, and what they'd like to happen.

Dr. Daniel C. Burnes is the newly-appointed president-to-be of the Managed Care Corporation, an interesting organization — interesting phenomenon — which I'd like to know more about myself. It's a spinoff, as they say, of the venerable Harvard Community Health Plan, which was mistakenly identified in my paper — though not by myself — as the granddaddy of all HMOs, a bit of Boston parochialism. We know, of course, that Kaiser-Permenente on the West Coast was the true granddaddy.

Before Dr. Burnes came to Harvard Community Health Plan in July of 1983 as a special assistant to the president, he held various positions including medical director, chief executive officer, associate medical director and so on. In other words, he was on both sides of the management fence: doctor, and I suppose more broadly, manager for the Kaiser Foundation Health Plan in Connecticut and the North Central Connecticut HMO, which was a predecessor organization.

Daniel C. Burnes, M.D.

President, Managed Care Corporation

Daniel C. Burnes is President of Managed Care Corporation, a health maintenance organization in Boston, Massachusetts. Before assuming that position in June 1984, Dr. Burnes was Special Assistant to the President of Harvard Community Health Plan, Associate Medical Director of the Kaiser Foundation Health Plan of Connecticut and CEO and Medical Director of North Central Connecticut HMO in East Hartford. Dr. Burnes holds degrees in both medicine and public policy.

Burnes: I'm fortunate to be on a panel with some of the larger and more successful delivery systems in the country. Managed Care Corporation is a new company set up by the Harvard Community Health Plan and managers of our company to develop HMOs and alternative delivery systems, both here in New England and throughout the country. I find it very difficult today to be able to predict what American medicine will look like in the future. I do believe that there will be some dramatic changes in the different types of systems I'd like to lump under alternative delivery systems.

First of all, we think there is a dramatic change in the reimbursement mechanism occurring across the country. It is difficult to see the extent of this change in one geographical location. We've had the opportunity to see and interact with physicians in hospitals across the country over the last year and it is, in my mind, very dramatic. Industry and government have now taken dramatic steps in changing this reimbursement, and they are finally setting up systems that are changing how medicine is practiced. The government has introduced the DRG (diagnosis related group) system. This has caused a completely different way of doing business by the hospitals in the United States.

Industry is now becoming a prudent buyer. That's evidenced probably most dramatically by the new General Motors contract in which GM is going to be offering three different options: HMOs, PPOs (Preferred Provider Organizations) and a fee-for-service system that will require mandatory utilization systems. Lockheed is requiring first-year employees to join HMOs; they don't offer the traditional fee-for-service system. The essence of this change is that the entire medical care system is moving from one which is an open fee-for-service system to one which is a closed fixed-price system.

When I say "closed," I mean those institutions — federal government or industry — which are purchasing health care and which have stated that they will no longer pay on a fee-for-service basis, but rather will have some type of fixed-price system. We see this dramatic trend moving across the country.

HMOs are the most well-developed systems in the country today to deal with these fixed-price, closed systems. They can meet the needs of the purchaser, the providers and the consumers of health care.

in the past five to 10 years, it has been a real question of whether these organizations would last, and what type of viability they have. In my mind, it's now not a question of whether they will last, but which particular ones will be the most successful, and what new types of systems will be developed. From a physician's standpoint, in those cities in which there are a number of HMOs, it is no longer a question of whether they will work for them, but which ones.

It's been clearly demonstrated that HMOs can deliver health care at a 10 to 40 percent lower cost than conventional insurance plans. The main reason for this is that they have demonstrated substantially lower hospital days per thousand, in some cases, as much as 35 percent lower. Their growth over the last year has been dramatic. They have increased by 15 or 17 percent and now total approximately 240 in the country.

The enrollment has grown by 15 percent this past year to a year-end figure of 15 million. This translates into a national enrollment of about 6.5 percent. Some organizations during that period of time grew up to 75 percent. If this growth rate lasts, and there's every evidence that it will, by 1990 at least 15 percent of the population will be enrolled in HMOs.

The issue of quality comes up quite often and it's difficult to measure. From the consumer standpoint, with the growth rates that I have just given you, it's clear that the consumers are voting with their feet and finding that these organizations are satisfactory to obtain their health care from. The studies that measure quality in these organizations show, in general, that they are as good as any fee-for-service system.

Let me elaborate. We know that HMOs have more control over the quality and the types of physicians than those in the open fee-for-service system. We don't really know how to measure quality in these organizations. We know that the prescribing patterns in HMOs are the same as those in fee-for-service. We know that if you look at some measures such as the controlling of hypertension, both fee-for-service medicine and HMOs show substantial gaps as to the type of control and quality of control that the researchers would expect.

There is evidence, however, that measures of health status such as disability days are lower in HMOs.

Also, there is the issue of skimming. Some people say HMOs take the healthy people in the population and enroll them, but Kaiser-Permenente, the "Granddad," has looked at this quite critically and found in several samples that their population was, in fact, sicker than those on the commercial-insurance side.

In summary, HMOs have established themselves as an integral part of the United States health system and are poised to take an active role in the competitive environment. The organization that we have started, Managed Care, has been created to form HMOs and other types of managed care systems. We are interested in providing management services to physicians and hospitals to allow the hospitals and the physicians to compete for their market share. The services that we provide include basic management services, market analysis, appropriate benefit packages, day-to-day management, financial systems and management information systems.

> There is a dramatic change in the reimbursement mechanism occurring across the country.

Our organization believes that any of these alternative delivery systems has to consider some important points in the future. First, the consumer will demand a quality product. Quality is going to be primarily defined by the patient, along with physicians and hospitals. The consumers will become more knowledgeable about the types of service they purchase and will consider such things as access, ambience and technical quality. Second, the purchasers of service — government and industry — will become extremely sensitive to price. Any system, whether it be an HMO or a PPO, will have to be cost competitive to survive. Third, HMOs will have to be fair in their reimbursement and relationships with providers for hospitals and physicians. Physicians don't make good employees. Hospitals are now interested in becoming an integral part of the insurance mechanism of medicine. The challenge that we face will be to create successful systems that will meet the needs of these two groups of providers.

Finally, HMOs and alternative systems will have to be well managed. Marketing will have to be professional, financial systems precise, and utilization and quality of these systems effective and efficient.

HMOs were established to provide high quality health care in the competitive environment. They have the potential for dramatic growth in the future, and those organizations that are dedicated to quality first and foremost will be the most successful.

Knox: You'll have to excuse me if I don't refer to Jake Getson as "Mister". I don't know of anybody in Massachusetts who does, even after he was elevated not long ago to vice president of Health Programs Development for Massachusetts Blue Cross/Blue Shield.

He's also formidable in his credentials and his presence in Massachusetts. For eight years before going to Blue Cross in 1980, he was the master architect of the State Health Plan, which might come back to haunt him some day. He now is in charge of a diverse set of activities, including managing and developing — making grow — the HMO line of business, which he will tell you has been, as Dr. Burns indicated, phenomenal in its growth recently.

He is also responsible for providing to corporations, activities in regard to the elderly and non-group populations, and responsible for the implementation of a long-range alternative-delivery-systems business plan.

Some of what this means is that he does not endear himself to hospitals and doctors in Massachusetts because he is setting up very successful competing organizations and reimbursement structures. I'll let him tell you the rest.

Jacob Getson

Vice President of Health Programs Development, Blue Cross Blue Shield of Massachusetts

Jacob Getson, Vice President of Health Programs Development for Blue Cross Blue Shield, is responsible for implementing Blue Cross' long-range alternative delivery system plan. This plan focuses on establishing comprehensive health systems, principally health maintenance organizations, which link the financing and delivery of health care.

Mr. Getson came to Blue Cross Blue Shield as Assistant Vice President of HMO Programs in June 1980. Prior to that he served as Assistant Secretary for Health and Human Services, Commonwealth of Massachusetts, Assistant Commissioner of the Department of Public Health, and Executive Director of the Office of State Health Planning.

As well as serving on the boards of several health plans, Mr. Getson is a member of the Massachusetts Health Care Cost Coalition, an officer of the Massachusetts Health Council, a board member of the Boston Forum for Health Action, and a member of the Board of Directors of the American Health Planning Association.

Getson: There are two key facts to know about me and I think that's enough. One is, as you can tell from the silhouette, I played football in college for a team that lost 21 straight games, and I still can smile about the experience. I've learned to live with very small victories. I also worked for 10 years in Massachusetts for three separate governors, so I'm a survivor. In those two things, you'll get a little bit of a flavor of what has gone on in the 15 years that I've been in Massachusetts. It's been a very interesting experience dealing with evolving health policy.

One word of caution. When you speak at a university, you tend to get a little too intellectual. That's never been my problem. I'm going to talk plain. I'm going to tell you exactly what I think, and you can take it for what it's worth.

First of all, I was the principal person in three governors' cabinets responsible for cost containment and health care reform in Massachusetts from 1970 to 1980. During that period, the Medicaid budget, one key measure of health expenditure in Massachusetts, went from $300 million a year to $1 billion and hospital-cost inflation went up an average of 25 percent a year. The cost of traditional insurance went from $700 a year to $2,500 a year. So, I didn't do such a tremendous job in cost containment.

We engaged the industry in a debate of rhetoric, but the reality never quite meshed. That has changed.

The crisis in health care in Massachusetts really hit home, and it was one of despair. The crisis was a crisis of nobody knowing what the hell to do to make any change in the trend lines of health care costs; hospital costs going up, no matter what action the state or federal government or insurance companies took; the number of doctors in Massachusetts coming out at the fastest pace in the history of the United States. Our joke is that, if you're in Boston and you fall to the right, you hit a teaching hospital; if you fall to the left, you hit a medical specialist. We have one of the highest concentrations of medical and health care providers in the United States, and we have a fine and excellent health care system, but one which is slightly conservative in practice.

The problem in our state in the late '60s and early '70s is that it was the most costly, if not in the United States, the world. Health care expenditures by any measure in Massachusetts was 40 percent above the national average and growing faster, and nobody could do anything about it. We started in the early '50s and '60s on what was a public policy at the federal and state level of expansion. It was a question of how quickly we could get the medical schools and nursing schools and hospitals to build and grow and expand. The question was: Could we match the rhetoric of a comprehensive high quality health care system as the right of all people in America? Hill-Burton passed and Medicare passed and Medicaid passed. Insurance companies measured their productivity in terms of how fast they could pay the claims to health providers.

Nobody could estimate the ability of health care providers to expand and grow, stimulated by a fundamentally fee-for-service payment mechanism. If you think about it, if we ever wanted to design a prudent health care system, the worst thing you could ever do is design a system of payment which paid piecework, by unit, by intensity and volume.

Think about the fire departments in all of your communities. Can you imagine paying the fire department by the size of the fire or by the number of fires fought? In Boston, we've been reading about some firemen who ended up in prison when budgets ran out and activity like that grew. But that's exactly how we, as public policy people, all through the last two or three decades, decided to pay the health provider.

We pay fee-for-service, we pay cost or charges, and the incentives, unfortunately, that are built into that system are to do more activity. If you spend longer with a patient or bring them back, you get more payment. It is impossible to contain costs under that payment mechanism.

So, what did we do? We decided we really have to control this emerging giant of an industry, so we said we're going to develop the most intense and coordinated regulatory apparatus to control the provision of health care. What we're going to do is we're going to create certificate of need and planning agencies. We're going to create rate-setting commissions and PSROs (professional service review organizations). We're going to regulate this beast into submission.

Quite frankly, we engaged in a battle of rhetoric, while the wheelbarrows of cash were being taken from public and private insurance companies out to hospitals and health care providers.

I'm not making the providers villains in this because it is exactly the way all of us created the system for growth, and we got what we deserved. At the period of time when the regulatory apparatus in Massachusetts and Rhode Island were gearing themselves up to control the industry, the hospital expenditures and health care expenditures were going up faster, except during the slight period when the wage and price freeze went on.

> Traditional insurance programs and traditional health providers are altering their delivery systems to look, taste, and feel like the HMOs themselves.

We started in Massachusetts in 1978 and 1979 by putting together a 10-year plan on health care and the price for health care, and then look at the aging population. You have a doomsday scenario in front of you — a situation in which the inevitability of collapse is not far away.

I can remember running up and down the state in the early and mid-'70s, talking to hospitals and businesses, saying that we would be in the danger zone when the amount of health care expenditures and the GNP crosses 10 percent; when the cost of health insurance crosses $2,500; when the Medicaid budget crosses $1 billion. They didn't respond too well in terms of changing behavior.

The net result is that all those things happened and, quite frankly, something very unique did start to happen, and that is the business community, feeling the pinch of high taxes and the cost of health care, started to walk with their feet and started to change basic health coverage. This happened in the mid-'70s, and it happened nationwide, and it happened particularly in Massachusetts with business, both small and large, taking unprecedented action to change what they viewed to be the most significant drain except for taxes on the cost of doing business. Some of them left the state.

The second highest reason given by employers for leaving the State of Massachusetts in the mid-'70s, besides the high taxes, was the high cost of health insurance and health care. Business after business went south and to the Sunbelt, using as part of the reason the high cost of health insurance.

Companies jumped to co-pays and deductibles, changed carriers — health insurers who would low-ball the rates for a year or two to get the business to change, and then increase the rate. Companies in Massachusetts in the mid-70s bore the brunt of 30 and 40 percent rate increases every year to cover the cost of health care and, in particular, hospital cost, which represented about 50 percent of the total health care expenditures in the state.

How do you get out of this mess? Not easily, and not without a certain amount of controversy, but certain things have happened which I never thought would happen in Massachusetts. At the time in which I'm talking about, I was in the state government, working on cost containment, and Blue Cross had about 60 percent of the insured market in Massachusetts. The Harvard Community Health Plan was just starting — as a matter of fact, in a partnership with Blue Cross and Blue Shield. It was one of the first HMO ventures in Massachusetts, and there was a lot of skepticism as to whether it would take hold. I can remember debating in our own shop as we made predictions in the state health plan that, by 1990, if our wildest dreams came true, 10 percent of the state's population would be in enrolled in HMOs in Massachusetts. What a change that would be.

We set that policy and help put some things in place to encourage the enrollment, and there was a lot of argument over whether that could happen. We were told people would never leave their physicians, people would never leave their doctor relationships, they would never shift their hospital allegiances, they would never move into the control of a managed-care system. The debate raged whether it would be 3 percent or 8 percent or 10 percent, and whether in fact an HMO could enroll outside of the urban areas, and could enroll the elderly and the Medicaid recipient.

We started the major battle to get the HMO accepted in Massachusetts and I would say one of the smartest things I ever did — and against my better judgement at the time — was allowing in the HMO legislation that passed, a provision for all types of HMOs. The people who worked for me and who worked in the state government were very biased toward the closed-panel HMOs, the Kaiser and the Harvard model that you all know and read about in Rhode Island, a model in which the physician works on salary or on a capitation payment.

There was a great debate inside the administration whether to allow the IPA (individual physician association)-type of HMO or Individual Physician Practice Association. We made a calculated political decision. We would never get the staff models accepted into law if we didn't give the doctors the IPAs. We made probably one of the smarter decisions that I made in my government career, which was to allow the HMO law to have all three. Immediately, the doctor foundations jumped into the IPA business, feeling that with that available, nobody would join the closed-panel HMOs.

So, we had three major physician-based IPA systems which came up in Massachusetts in the late 1970s and they have been a protective glove for the growing closed-panel system, because the doctors who were in the IPA couldn't attack HMOs because they were in one themselves.

What's been the result? I've talked about a 10 percent growth for 1990. As of today, 12 percent of the state's population is in HMOs. Blue Cross and Blue Shield has a net worth of eight operational HMOs serving a quarter of a million people. There's another HMO, the Harvard Community Health Plan, which has

around 200,000. There are 20 other HMOs in Massachusetts serving similar networks of population. It is a phenomenal situation — 650,000 people in HMOs. The amazing thing to me is that, in order to survive, the traditional insurance programs and traditional health providers are altering their delivery systems to look, taste, and feel like the HMOs themselves.

So, if you use the broader definition of managed care, I would say that 75 to 80 percent of the total population in Massachusetts by 1990 will be in structured, managed-care systems, and that's a phenomenal change in practice patterns.

I'm a firm believer that the HMO model, whether it be IPA or staff or group, is a better health delivery system — not only cheaper, and more efficient. It is better in the sense that it is comprehensive. It is better managed. And it's better in that it does not only treat you when you're sick and in trauma, but there is a financial set of incentives to treat you, and maintain you, when you're in a stable condition.

I'll leave you just a couple of numbers to give you a flavor of why this is so important to all of us. Traditional health insurance uses for the under-65 population in Massachusetts is 700 hospital-days per thousand people. One of the reasons traditional health insurance is so expensive is that they have to buy that amount of hospital days at roughly $400 or $500 a day. You can imagine the impact of that $2 billion a year going into the hospital industry to pay for hospitalization of Massachusetts residents.

The HMO, for the same age-adjusted population, uses 400 days per thousand. So we're talking about immediate savings to the subscribers and providers of health care, the difference between paying for 400 days versus 700.

All the other measures are down as well: the lengths of hospital stay; the cost per day for hospital-days; admissions per thousand; tremendous change in the use of in-patient hospital services. That can pay for preventive benefits, pharmacy and physician visits, and still reduce the premium.

The most exciting thing to me is not the under-65 group business, but the Medicare over-65 business. We all read about the public debate in terms of Medicare and Social Security, and the fast retreat of the federal government from the care of the elderly. The compact that we made with the elderly when Medicare was passed was that the Medicare program would serve to cover 80 percent of the cost of health care of the elderly population. It covers 50 percent now and is dropping dramatically every year. It is the biggest single non-defense drain on the federal budget, and is growing still out of control.

Why? The over-65 population in Massachusetts uses 4,400 hospital-days per thousand people. The amount of health care resources that the over-65 use is almost 10 times that of the under-65 population. In Massachusetts, Blue Cross/Blue Shield is sponsoring the Senior Plan, a demonstration program to cover 20,000 over-65 in our series of HMOs, and the days per thousand for that population is 2,000 days per thousand, as compared to 4,400. Can you imagine?

We have to charge for our Medi-gap insurance in this state, $47 a month to cover the gap between Medicare and the Blue Cross Medi-gap Insurance Policy. In our HMOs, it's $15 a month, full coverage, pharmacy included, eyeglasses once a year, a total package of care to the elderly. What is more important to me than the price difference is the fact that in the 20,000 people coming from the fee-for-service system into our Senior Plan, we saw a staggering amount of untreated illnesses in the elderly. We have found people who have very bad primary-care connections. The elderly don't have good primary-care doctors, their doctors have died or are retired, or gone somewhere else, or have cut back in their practice. The story that the elderly have great doctor relationships is a myth.

The story that the elderly have great doctor relationships is a myth.

We have found untreated illness. We have found that a significant cost and cause of hospitalizations is the deterioration of disease which has been caused by people who have tried to medicate themselves and maintain themselves in their home by taking prescriptions — five and six different prescriptions that they have been taking for 15 years — with very little in the way of good checkups, good connections, prevention, maintenance and advice from their physicians.

That's why I'm optimistic about Massachusetts. There's just been a report out from the Massachusetts Hospital Association. With the population aging, admissions are down 15 percent across the state. Hospital costs, instead of being 40 percent higher as across the nation, are down 30 percent and dropping.

We, for the first time as an insurance company, are able to drop premiums, cut the rate of increase. We have been able to give more benefits for less money every year in the last three years to a number of accounts, and that's a nice feeling.

The ethical and moral issues of health care don't go away in the HMO system. The same problems that I have with the over-utilization on the fee-for-service side, I have on the capitated or salaried side to make sure that we don't skim only the young and healthy, and that we use health screening to keep the sick people out of HMOs, or that we deny care to people to make a profit. Moral and ethical issues don't disappear; the problems don't disappear. But they change dramatically, and they are changing in Massachusetts.

Knox: Dr. Dunn, who is a Doctor of Dental Surgery, was Governor of the State of Tennessee from 1971 to '75. He was snatched up by the Hospital Corporation of America soon after leaving office, and he has served as Vice President of Public Affairs prior to his appointment in '77 as Senior Vice President of HCA.

Winfield C. Dunn, D.D.S.

Senior Vice President for Public Affairs, Hospital Corporation of America, former Governor of Tennessee

Winfield C. Dunn joined the management of Hospital Corporation of America after serving for four years as Governor of the State of Tennessee (1971-1975). He became Senior Vice President for Public Affairs at H.C.A. in November 1977.

Before becoming Governor, Dr. Dunn practiced dental surgery in Memphis, where he served on the board of trustees of the City of Memphis Hospitals. He currently serves on the boards of H.C.A., First American Bank, and Tennessee Natural Resources, Inc. He is also President of the Federation of American Hospitals.

Dunn: My company, the Hospital Corporation of America, HCA, has been successful since its founding by two physicians and a successful businessman back in 1968, shortly after the Medicare and Medicaid programs had taken wing as a result of our national commitment to people in this country and their health care needs. The company started with a strong belief that free enterprise could deliver a cost-effective, quality health care product to people.

Today, HCA, along with other investor-owned companies, manages 9 percent of the beds in the country and 15 percent of the hospitals. Of the hospitals we operate, approximately half are owned and half are managed for other owners. HCA hospitals are situated in 42 states and seven foreign countries. We have approximately 65,000 employees and we're responsible for an additional 55,000 employees in the hospitals we manage. We currently operate 62,000 beds with approximately 40,000 practicing physicians.

At HCA, we pride ourselves on a strong partnership with physicians, a relationship built on quality patient care, excellent facilities and equipment, and well-managed operations. We continue to believe that physicians are not only a prime customer of a hospital, but are also integral to a strong working partnership. One of HCA's major strengths over these 18 years has been found in the relationships which have been built between the company and the communities in which our hospital serves, and the medical staffs associated with those hospitals.

The company's mission statement emphasizes these relationships and our commitment to the delivery of quality patient care. It stresses leadership in health care; it stresses excellence; it stresses improving the standards of health care in all the communities in which we operate; and it stresses the generation of measurable benefits for the company, for the medical staff, for the employee, for the investor and most importantly for the patient.

There are many of you who find the words "investor-owned" and "hospital management" unfamiliar. In reality our health care system has always had a powerful nonprofit and for-profit mix. The pharmaceutical, the medical equipment and supply, and the insurance sectors, among others, have always rewarded their investors with dividends and profits.

A substantial number of hospitals and medical schools operated as for-profit institutions up until approximately 50 years ago. Stimulated by the first signs of a changing economy and relief in the free-market society, the investor-owned concept began to re-emerge in the late 1960s, and HCA was one of the first. Success has come in part because we applied the corporate model to health care delivery — sound management and good business practices adapted to the hospital setting.

These principles are well known in the business of health care. HCA has applied them consistently; they've helped us set a course that's taken us from our roots as a small hospital company to becoming a hospital-based integrated health care company of the future. We began with a premise that the private enterprise sector could deliver cost-effective quality health care. Our company's founders believe that several hospitals operating under a single management umbrella could enjoy the economic advantages of purchasing discounts, volumes of scale, legal expertise, human and managerial resources, and access to capital — an approach, I might add, that became a model for many of today's not-for-profit multiple-hospital management systems.

HCA, however, added the stockholder-investment dimension to the model as a tool for forming capital. That was in 1968. We were a $5 million company with 11 hospitals. I contend that there was a great need, and that for many reasons we were in the right place at the right time, doing the right things in the right way. Today, there are over 400 hospitals in our system, and our revenues are measured in the billions of dollars. This wasn't accidental, nor was it due simply to sound management. It comes from a strong commitment to leadership and to excellence in health care, and from a determination to improve the standards of care in the communities we serve.

Our future growth plans, and especially our strategies for providing quality care at reasonable prices, will build upon our commitment and our past. Today, the hospital industry is undergoing a dramatic

shift from a position which has long assumed that "more is better," to an attitude that insists that "more efficient is better." We're moving from a hospital system which knew little about competition to a market-based health care system in America.

Beginning in the 1960s, federal health care policy was fueled by the premise that Americans needed more medical care than the market could provide. You have heard recitation after recitation of the history of those adventures in social experimentation by our country; for the most part, they were planned with proper attitudes and with deep concern, but they were flawed in many ways.

During this process, and these times in which our country committed itself to bettering the condition of many of its citizens, the stage was actually being set for two historic developments which have occurred rather recently. Number one, the Tax Equity and Fiscal Responsibility Act of 1982 and the Social Security Act of 1983, both of which in concert have revolutionized the financing of health care by introducing the fixed-price approach to hospital payments, and the introduction at long last of competition into an industry that has been virtually exempt from such forces.

These developments have taken us beyond the threshold of change, and we are witnessing more than simply a reorganization of our health care resources in this country. Rather, we are fundamentally rethinking and reforming the way we make health care available to ourselves, to the American people.

Clearly, hospitals will remain at the heart of our system and will continue to do much of what they do now, but they will do it quite differently. They will develop new ways to provide quality care in more cost-effective ways. Part of this new philosophy will increasingly embrace competition as a means of keeping health care consumption and costs in line. For the first time, the classic free market principles will prevail in the delivery. In the past, we have treated health care as though it were somehow isolated from the rest of our economy.

Cost-based reimbursement programs offered no incentives for operating efficiencies. Today, we find ourselves in a competitive environment, cost conscious and free-enterprise oriented — the dimensions of which are expanding exponentially.

An interesting aspect of this new philosophy is the current focus on privatization of many social functions and responsibilities which were once assumed to be the prerogative of government. The federal government, until recently the dominant force in making certain social services available to all segments of our society, is reducing its presence in those areas and in the process is creating a vacuum. It's all too apparent that keeping vast quantities of government-collected funds on social problems simply won't produce permanent solutions. And so, the private sector is being challenged to play a larger role in addressing these opportunities and, of course, they include health care.

Social and demographic changes are also reshaping the health care environment. As our population ages, the incidence of chronic illness, along with growing demand for hospital services will drive health care costs forward. Many of the beds that we find empty will be much in demand as the years unfold.

Another change has to do with the health care consumer who is better educated than in the past, because individuals are now paying more of their health care bills directly out of their own purses. They are no longer passive pawns in the health care equation that they've been in the past. They're shopping for health care based on price, but also based on quality. Today's consumers are more health and wellness conscious and are exercising discretion in choosing their health care options. What was once a seller's market for the hospital is now clearly a buyer's market.

> We began with a premise that the private enterprise sector could deliver cost-effective quality health care.

HCA believes that these changes are positive for the long run and for the future of health care and the people its serves, and that responding to the new environment will require strategies which are aimed at providing quality care at reasonable costs. Our strategy, as a company, will continue to build on that awareness.

First, we will continue to promote a strong orientation with the physicians. That's essential, as our company views its future. Both our mission statement and our day-to-day practices continue to demonstrate that we attach a great deal of importance to the role of the physicians in the success of our organization.

Second, we built a reputation for quality and responsibility. We're in an industry where quality will always be the key determinant of success. We believe our emphasis on quality will provide the company with a competitive edge in a rapidly-changing marketplace, and we're making our plans as a company accordingly.

Third, we have a well-positioned base of hospitals upon which to build. We have a strong multi-hospital presence in many of the large-market areas of our country.

Fourth, our administrators have worked for years under the philosophy of decentralization. Their ability, as chief executive officers of hospitals, to respond to the changes that are occurring in their marketplaces is excellent because these administrators have had primary responsibility for their hospitals and to their local communities.

Fifth, we carefully equipped our hospitals with the technology that is appropriate for their size and their community need.

Sixth, we believe the values that are deeply ingrained in our corporate people are a tremendous strength. We've consistently been able to attract and retain the very best people in the field because of our corporate principles and the mission which we espouse.

These strengths and resources have facilitated our evolution from a hospital company into an emerging integrated health care services company. Our business plan is now taking us into PPOs and PPO-type programs for business. We are entering the health plan business. We've applied for HMO licenses in 15 states to cover our hospital markets. We're also

supporting our physicians by linking them to HCA hospitals and health plans. We develop and operate regional laboratories, and we operate a medical research company that manages clinical trials. We own the largest independent ambulance company in the United States, because we believe that as more public services are transferred to the private sector we can develop partnerships with local communities to provide cost-efficient, basic and advanced life-support transportation services.

We're bringing the financing side of the business closer to the delivery side. We believe that hospitals in the 1990s will be not only providers of health care, but will share in the insurance-risk of providing that care. This will happen among insurers, providers and purchasers, who will work together to develop arrangements which include the insurance risk component as well as the cost-effective service delivery component.

> Consumers will seek competitive prices, but they will make absolutely no compromises regarding quality.

What this points to, we think, is the next step in hospital industry's evolution — the integration of providers, financers, and purchasers at risk. On the delivery side, a variety of facilities and locations across a wide geographical area will package and offer a full range of health care service to its members. These providers will be extensions of our acute-care community hospitals. They will direct patients to, and they will receive patients from, other providers in those networks. Patients will be transferred to lower-cost alternative providers, as need dictates.

On the financing side, we will see a full range of health plans with varying degrees of provider and purchaser risks. Providers will share in and control the risk of making its services available through an insuring function. Linking the delivery and the financing sides will be various management control systems and contractual models that are currently being developed, that will join physicians, consumers, facilities and payers in the network. HCA sees this as a model and variations on a model for the future, and we're working diligently to pioneer in their development, just as we pioneered the use of the corporate model in the delivery of health care services. It's a model that will be adopted by investor-owned companies and nonprofit hospital systems alike.

As the health care industry moves into a new era, the one thing it must not underestimate is the importance of quality. Consumers will seek competitive prices, but they will make absolutely no compromises regarding quality. Without strong quality emphasis there can be no winners in health care; and at HCA, we believe that our commitment to excellence will move us forward.

Questions and answers

Knox: It's the moderator's prerogative to ask the first question, and I think it's the largest question all three touched on. We're talking about anticipating the problems of market success and issues of concentration of ownership and power of individual market areas, whether they be states, regions or cities. Blue Cross maintains a lot of control over doctors and hospitals in the traditional marketplace in the reimbursement system, at least doctors and hospitals in Massachusetts think so, and I think the recent laws in Massachusetts have actually delegated more power to Blue Cross in many ways. And it is heavily into acting as a provider and a competitor to the HMO system, and that's raised some issues in Massachusetts.

In HCA, as Dr. Dunn has said, there are already many cities where they have a strong multi-hospital presence. I assume there's a great incentive for the company to build on that, to garner a larger market share, if they can. This raises issues of whether we should worry about concentrations of that kind. My question is whether that is a worry, whether one can identify it at this stage and how you respond to questions when they are raised by your competitors? Anybody can speak first. Jake, what do you think about Blue Cross' market leverage in this?

Getson: There are 21 HMOs in Massachusetts, all competing for the subscriber. There are a multitude of health insurance companies, all marketing to accounts. Virtually every company in Massachusetts involving a hundred subscribers offers a multiple choice.

Now, companies like Polaroid, Stop & Shop, and *The Globe*, and the state offer employees 15 or 16 HMO options. The subscriber makes the choice, tied to the proximity of where they live, not necessarily where they work.

It's a whole new dynamic going on. It's community-based, and where I live I have five HMOs that I could join. My question is: How accessible are they? What providers are in them? What is the benefits package? Then there's some real choice going on.

Knox: What if over the next few years we should see a concentration and some of these smaller ones fall away, and maybe Blue Cross and HCHV (Harvard community health plan) emerge as the most concentrated providers.

Getson: I'm for choice. I believe that there ought to be as much choice as possible. I would not like to see it consolidate to one or two providers, at all.

Dunn: I think we've got a system in this country that pretty well assures a certain level of comfort for all of us.

In the case of HCA we've had an example of what can happen when you become too concentrated in a particular market. The Federal Trade Commission brought us to the bar because we owned 40-plus percent of the hospitals in the Chattanooga, Tennessee area. We were directed to divest one hospital in this Chattanooga area. We're going to resist that very strongly.

But the point I want to make is, I simply see no reason at this point for the public at large to be concerned about what are very natural reactions to the conditions that currently exist in a relatively free society.

Question: HMOs have a pretty clear interest in doing business with hospitals that run relatively efficiently and at relatively low cost. As you capture more and more of the market, that's going to leave a smaller and smaller percentage of our well-insured people to be admitted into the more expensively-run hospitals. How do you think the teaching hospitals will remain solvent when they can no longer attract all these people?

Burnes: If you look at the changing reimbursement pattern, the teaching hospitals are in for a very stormy time. The government is asking who's going to pay for the teaching. There's no question that, as competing alternative delivery systems develop in an area, they're going to force the hospitals to become competitive. One of the solutions to that which was mentioned here today is that the hospitals themselves could become an integral part of these delivery systems. Given that focus, they then become delivery systems, not just acute-bed institutions.

Unfortunately, very few of the teaching institutions in the country today are looking at the world this way, and it's going to be interesting to see what happens to them as this evolves. I think they are in for a stormy time.

Knox: I think there's a lot of teaching hospitals that are not in the position to launch these kinds of networks of care-provider organizations. However, many of them are trying, but they feel beset and besieged and others may have gotten in the door ahead of them.

Getson: The exciting part for me is to see the change in attitude of the people in the teaching hospitals in Boston who we've been talking to over the last 15 years.

We went into a debate four or five years ago with the big teaching hospitals in Boston. We said you can't use us only for tertiary, high-intensive services. We must have community medicine as well, and primary care.

There was a real dilemma of the hospital administrators, and not a good answer. But what has started to emerge is that a number of big teaching hospitals in Boston are starting to reorganize and break apart into 100-, 150-, 200-bed community hospitals under a different cost-allocation system. They are doing it because if they don't, they won't get the patient flow.

What we're seeing is a reaction to external forces starting to go in a business-like way. There are probably 5,000 to 10,000 more hospital beds in place in Massachusetts than are needed out of a 25,000-bed complement. And the need is dropping as these managed-care systems come into place.

The answer is that the system, as it gets more efficient, is going to have to lean up because it's wasteful to maintain all that excess capacity when the money could be redirected to community and out-patient care.

Burnes: I think these doctors are going to become even more extreme when the governments and the states realize that they have to put their Medicaid patients into a fixed-price system. We're starting to see that across the country. Arizona is one of the first states to have done that. That's going to hasten this whole process.

Dunn: I'd like to make an observation regarding medical teaching institutions — not in direct response to your questions. In the last several months, very dramatic things have happened, one in Nebraska, where Creighton University decided to literally sell its university hospital, St. Joseph Hospital, a 500-plus bed facility, to, I think, American Medical International, which is an investor-owned hospital management company. We, HCA, have recently signed the papers which will lead to our acquisition of the Wesley Medical Center Hospital in Wichita Falls, Kansas, which is the largest Methodist hospital in Methodism and is an excellent teaching hospital.

I'm sure many of you read that George Washington Hospital in Washington, D.C. is considering a new relationship of that kind. And reference was already made to McLean Hospital here in this area which has been pondering its fate, based on its very serious capital needs for the future.

So these things are all coming rather rapidly, and will continue to happen as the years unfold.

Knox: Governor Dunn, why do these companies, including yours, want to acquire teaching hospitals? How far do they want to go in supporting the classic resident and teaching functions? Is it window dressing?

Dunn: I think, as much as anything else, it's a challenge to our system of management, and a challenge to the way in which we've applied our resources, to see if we can address the operation of facilities at that level, that dimension — providing not only health care services, but educational services as well. I think it's just a part of the growth pattern that will continue, and one that we are very happy to be part of.

But I would hope we will be able to demonstrate clearly that we can successfully deal with it before we acquire too many.

Question: If we can assume physicians will not be self-employed in the near future, how do any of you anticipate they'll represent themselves? Will they bargain on an individual basis, or will unions possibly arise?

Getson: They'll walk with their feet the same way the consumer does, moving from health plan to health plan. In some cases, they may get more organized, depending on the response. But if you look at the Boston area where you have so many competing health plans, one of the more phenomenal changes is the willingness of physicians to move from traditional reimbursement into a salary or capitated mode. There's choice, and if they can choose between Harvard and Tufts and Multi-group and Blue Cross, then they'll walk with their talents like I or anybody else does.

Burnes: The issue of managing physicians is a difficult one, but their motivations are no different from anyone else in that they're going to work in the organization which motivates them. There will be a multitude of different responses, and we've already seen it; we've seen unions, we've seen separate corporations. It's not going to be one type of work environment.

Cost vs. Care: America's Health Care Dilemma Wrongly Considered

Part I: The American Critique

Theodore R. Marmor

Professor of Public Management and Political Science, Yale University; senior advisor on health and social security to the Mondale/Ferraro campaign

Theodore R. Marmor is currently Professor of Public Policy and Management, Yale School of Organization and Management; Professor, Department of Political Science and Institution for Social and Policy Studies; and Chairman, Public Management Committee, School of Organization and Management, all at Yale University.

He has both his B.A. and his Ph.D. from Harvard, and taught at Harvard, the University of Minnesota, and the University of Chicago before coming to Yale in 1979. From 1979 to 1983 he was Chairman of the Center for Health Studies, Institution for Social and Policy Studies.

Professor Marmor is the author of numerous publications, including "The Politics of Medicare" and "Political Analysis and American Medical Care," and has served as editor of the Journal of Health Policy, Politics and Law. He has also served on the organizing committee for the Health Policy Conference on Canada's National Health Care System, The President's Commission on a National Agenda for the Eighties, and The Committee on Consumer Representation in Health Planning, M Institute of Medicine, National Academy of Sciences.

The question before us is how to clarify the seeming dilemma in American medical care: the dilemma between high cost on the one hand and the provision of valuable care on the other. It is my task to illustrate in what way this dilemma is "wrongly considered," before Robert Evans presents the example of how our northern neighbor, Canada, has admirably dealt with the same apparent dilemma.

First, however, we need to review the scope of what we are calling a dilemma — an extraordinarily expensive system of medical care which, for all its virtues, provides neither the quality of care nor the equality of access to care that would justify such costs.

American medicine today presents a very mixed picture of successes and failures. Although not last among industrialized nations in health status, the United States ranks lower than our level of expenditure and standard of living would indicate. In life expectancy, for example, American males rank 15th and American females seventh in the world. More than a dozen countries have lower infant mortality rates and comparatively Americans are losing ground.

These shortcomings contrast starkly with accomplishments of which American medicine can be justifiably proud. Among these we can count sharp increases in life expectancy in the last two decades, preventive vaccines for many often fatal diseases and cures for still others, and remarkable new diagnostic tools and life-prolonging technology.

Underlying the picture of these enormous contrasts is their cost. Table I illustrates the degree to which medical costs have soared in the past 25 years. The United States spent $322 billion dollars for medical care in 1982 — 10.5 percent of GNP. In 1983, this figure increased by 10.3 percent — in a year when the general inflation rate was only 3.9 percent — to an estimated $355 billion, or 10.8 percent of the GNP. The nation's medical care bill is now expected to reach some $700 billion in 1990 (12.3 percent of GNP).

Rising costs affect everyone: individuals, as out of pocket costs and health insurance premiums rise at alarming rates; employers, who pay over 80 percent of the cost of health insurance premiums; government at all levels, as Medicare, Medicaid, and local government expenditures continue to increase rapidly; and the nation, as medical care appropriates an ever-increasing share of our resources.

Table I: National Health Expenditures

Year	Amount in billions	% of GNP
1960	$ 26.9	5.3
1970	74.7	7.5
1980	249.0	9.5
1981	286.6	9.8
1982	322.4	10.5
1983	355.4	10.8
1984*	392.7	10.9
1987*	529.8	11.6
1990*	690.4	12.3

*projections

Millions of Americans do not receive the care they need while money is squandered on unneeded, unwanted, and sometimes even harmful services and unnecessary facilities. One-fifth of the nation's children are not immunized against polio and only half our children are fully immunized against preventable childhood diseases. Almost 900 counties have fewer than one doctor per 3,500 people, leaving thousands of communities without basic care. American workers find their employers forced either to cut back on their health benefits or to restrict wages to pay for increasing medical costs. Health insurance for ordinary Americans is eroding, leaving too many either unprotected or underprotected. For the first time in 30 years, from 1979 to 1982, the number of Americans without health insurance increased. In 1983, 14 percent — one of every seven Americans — reported that they could not get the care they needed because of cost, many because of unemployment. Financial barriers to access — let alone equal access — have grown much higher in the 1980s, leaving some 30 million Americans underserved.

At the same time, we waste money on inefficient and often ineffective services and facilities. Physicians order whole batteries of tests of doubtful utility but do not take time to talk with or examine patients. Many hospital beds are filled unnecessarily with patients who could be treated as outpatients, or treated elsewhere, or who

do not need treatment at all. Increased use of life-prolonging technology has led to a situation in which medicine too often prolongs dying, not living.

The problem is obvious. The United States faces the test of making access to affordable care a reality rather than an empty promise. In 1965, the passage of Medicare and Medicaid symbolized that promise to the elderly and the poor. In 1985 we face the continued erosion of that promise.

In facing this problem, however, must we confront the difficult task, the dilemma, of choosing between cost and care. Let me illustrate what I mean by the American health care dilemma wrongly considered. Recently, in *Newsweek*, Dr. William Schwartz of Tufts University claimed that "either we Americans accept the high and rising cost of hospital care, or we will eventually have to ration it." And he added that "Great Britain has long since taken the course and made its peace with it."

In other words, Dr. Schwartz is saying we are on the horns of a dilemma. Either we continue to pay more for medical care or we are going to have to cut off, in short order, some of our lifesaving technology, the very sort of thing that people worry about when they're sick. Schwartz's proposition presents, to my mind, a false dichotomy. It muddies the discussion about cost containment in the United States and contributes to illusions about our choices. The invocation of British evidence obscures rather than clarifies our choices. Let me be more specific.

There is a kind of specter that stalks the long-term American debate about cost containment. That specter is Britain's National Health Service (NHS)—if the United States were to clamp down on spending, if it were to impose some kind of strict central budget, based on something like the British model, then it would inevitably have to follow the example of the National Health Service and ration health care. Instead of being available on demand, health care would be allocated by physicians according to their own criteria of need and their own priorities. The result, it is argued, would be to import into the United States a system of queuing and waiting lists.

This case, as it is usually presented, is designed to evoke horror and revulsion. Its aim is to persuade the audience that anything remotely resembling the British system would be unacceptable in the United States. That, I submit to you, is the standard way in which the issue of rationing arises in the United States. It is illustrated, but by no means simply and uniquely, by a recent book by Henry Aaron and William Schwartz, "The Painful Prescription: Rationing Hospital Care."

One way that this question is often addressed is to examine just how Britain's National Health Service rations health care by comparing its provision of certain therapeutic procedures with the provision of those same procedures in the United States. The benchmark for assessing the performance of the NHS in this type of comparative study of medical procedures is rates of provision and use in the United States. For instance, in the Aaron and Schwartz book, they explain that, except for cases where there is evidence of overprovision in the United States, they "regard Britain as providing full care if it provides care as frequently and in the same general way as the United States does." Given the evidence of overprovision and overuse in the United States — particularly of various surgical and diagnostic procedures — it is far from self-evident that American medical practices are the best starting points for assessing the performance of other health care systems, or its own. This sort of descriptive study threatens to create a new myth because of the restrictive assumptions underlying its analysis and the conclusions that might be drawn on the basis of the presented interpretations.

These procedural comparisons reveal that some therapeutic procedures are as readily available in Britain as in the United States: treatment of hemophilia, bone marrow transplantation, and mega-voltage radiotherapy. Others, however, "are clearly rationed when compared with the United States." The overall rate of treatment for chronic renal failure in Britain is less than half that in the United States, the rate of coronary artery surgery in Britain is only 10 percent of that of the United States, the British hospital system has only one-fifth to one-tenth as many intensive care beds as the United States relative to population, Britain has only one-sixth the CT scanning capacity of the United States.

The problems start with the interpretation of these findings and the uses to which their interpretations will be put in American health debates. Why, one might well ask, would scholars of American medical care costs and control turn to Britain's experience at all? Great Britain is a relatively poor industrial state, with a unified parliamentary regime and a far more rigid class structure and a far wider spectrum of political ideologies than the

United States. These cultural and economic wealth differences are too great to conceive of wholesale importation of particular British health policies. And furthermore, Britain has been the only country, in the post-war period, whose physicians and hospital administrators are all directly employed by the state in a quasi- or actual-salaried service. Unlike the rest of the world, Britain does not have national health insurance or private health insurance, it has a national health service.

So I submit to you that there is a way in which, for purposes of the American domestic political debate, the example of Britain is invoked as a kind of bogeyman, not to clarify the debate over the options we have for cost containment but to muddy it, to provide a side issue in which this revulsive horror of long waiting lists is held out as a possible risk that we take seriously. The main point I want to make is that, if we think about care versus cost in such a way that "The Painful Prescription" and British evidence are used to inform our debate, we will have wrongly considered the relevant dimensions and will have used an example that is inappropriate for that purpose.

For purposes of estimating what American politics might do with an imported policy — like the British form of powerful central budgeting and clinical autonomy — the right method is to explore national circumstances and experiences as similar as possible to America's. Were direct simulation the purpose — estimating what centralized budgeting caps would work like in America, for instance — Canadian, Australian, and German experience would all be more promising subjects than British rationing.

Differences obviously reflect a variety of factors. They may reflect differences in the availability of resources — the most obvious explanation when comparing a country which spends only 6 percent of its GNP with one that spends over 10 percent. They may reflect differences in the incentives to physicians. The United States fee-for-service system clearly gives doctors an incentive to maximize activity, while the British system of salaried hospital doctors provides an incentive to minimize activity (to caricature only a little). Finally, they may reflect different traditions of clinical practice, and different views about what good medical practice actually involves.

The trouble, of course, is that all these factors are linked. In the case of the United States, the open-ended nature of the financial commitment to health care means that physicians can maximize their own incomes by adopting an aggressive approach to medical treatment. The environment allows the professional imperative to be defined in terms of throwing everything possible — in terms of technology and resources — at patients, irrespective of the chances of actually "curing" them. In the case of Britain, the result of the system of global budgets set for each hospital is that physicians are acutely aware that one patient who is over-treated means — in terms of the available resources — that another patient may be undertreated, or not be treated at all. The environment nudges physicians to adopt a conservative, cautious approach to treatment and forces them to be selective in their use of medical technology in its widest sense — as in the use of diagnostic procedures.

> In life expectancy, American males rank fifteenth and American females seventh in the world.

In Britain, for example, this situation persuades physicians to disguise rationing decisions as clinical decisions. Physicians internalize, as it were, the resource constraints and lower their clinical sights accordingly. To an extent this is true. Renal dialysis is a good example of resource constraints, where undoubtedly some patients are turned away to die on ostensibly clinical criteria. But in the other cases, cautious use of diagnostic procedures or chemotherapy for cancer, for example, may simply reflect a humane concern for the patient and an unwillingness to subject him or her to procedures which are unlikely to yield either significantly greater diagnostic certainty or life expectancy. In making such comparisons, one must emphasize the reverse conclusion for the United States — that an abundance of resources may persuade physicians to internalize their own desire to experiment with new techniques or to increase their incomes and transmute their own personal preferences into heroic medical practices.

It is quite clear that the British National Health Service gives less priority than the United States system to "quality of life" treatments such as hip replacement. Although all the evidence suggests that the NHS copes fully and competently with life-threatening conditions, it does not adequately meet the demand for procedures designed to enhance the quality of life. Still, the length of queueing times in Britain is frequently exaggerated. For example, while there may be instances of people waiting years for a hip replacement operation because they are classified as non-urgent cases, the median waiting time for orthopedic surgery is only 12 weeks.

All this is not to urge importing Britain's NHS into the United States. The two systems are anchored in profound differences of professional culture between the two nations, which reflect the differences between the two societies. A system which works well in a paternalistic society like Britain, with its lingering if ebbing tradition of deference to professional experts, would not necessarily work in an entrepreneurial society like America, with its emphasis on the engineering of ever-higher expectations on the part of consumers. However, it is to argue that Britain's NHS should not be used as a specter to frighten off people from a system of health care based on global budgeting, a system which, if ever adopted in the United States, would no doubt have to be cast in a quite different mold to take account of very different circumstances.

There is nowhere in the United States substantial support for the much more ascetic style of British medicine. American patients would be strongly opposed to severe limits on life-saving technology like kidney dialysis. American politicians are not likely to press for Draconian measures, except as scare tactics to ward off sensible cost control. As the Canadian example illustrates, it is possible to have American

levels of medical care in a comparably rich country with considerably lower outlays. That means less income for those in medicine, a painful prescription indeed. But the political realities of conflict over constraining the incomes of the medical industry should not be confused with the specter of sharp reductions in the level of services provided.

The Canadian Example

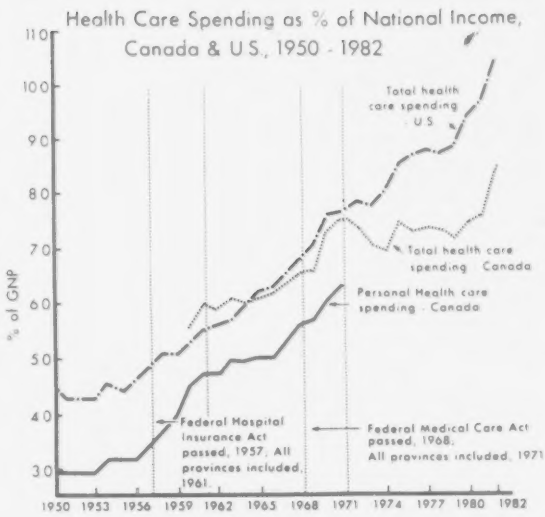
Why do I say that this formulation of the dilemma is misleading? Think about the world of American medicine we have described, a world that now spends almost 11 percent of GNP on care, a world in which 25 to 30 million Americans are not covered by health insurance; a world in which close to 25 percent of Medicare's $60 million budget is spent for care in the last month of life.

Now, contrast that situation with the circumstances of our northern neighbor, Canada. Canada spends under 10 percent of GNP, roughly 2 percent less than we do. Canadian national health insurance provides comprehensive coverage for every Canadian man, woman, and child. Consider, too, that in 1970 the two nations were spending exactly the same proportion of GNP. Since 1970, Canada has stabilized the share of its national resources going to medical care while, during the same period, our share of national resources spent on medical care grew from 7 percent to almost 11 percent.

Let me add a couple of other facts to this comparison. If you ask Canadians

> Only half our children are fully immunized against preventable childhood diseases.

whether they are, on the whole, satisfied with the quality of care they get, and their access to the services that Canadian medicine provides, the overwhelming majority would say yes. Ask yourself also to what degree Canada compares with the United States in terms of economic circumstances, or to what extent their society is more similar to ours than is Great Britain's, or to


Health Care Spending as % of National Income, Canada & U.S., 1950 - 1982
% of GNP
110
100
90
80
70
60
50
40
30
1950 1953 1956 1959 1962 1965 1968 1971 1974 1977 1980 1982
Total health care spending - U.S.
Total health care spending - Canada
Personal Health care spending - Canada
Federal Hospital Insurance Act passed, 1957. All provinces included, 1961.
Federal Medical Care Act passed, 1968. All provinces included, 1971

what extent is the distribution of their population from the Maritime Provinces on the east coast to British Columbia on the west coast similar to population distribution in the United States. I think you will conclude with me that Canada in almost every way is more comparable to the United States than is Great Britain. And if it is possible, in a society not identical but roughly comparable to ours, to provide comprehensive medical care at 2 percentage points less of GNP than we now spend, there would appear to be a very good basis for believing that we are spending more than necessary.

Let's look at the implications of this in quantitative terms. If we had experienced the rate of increase in costs that Canada experienced during the 1970s rather than our own, we would be spending roughly 9.6 percent of GNP on health care — 70 billion dollars less than we are now spending.

Now, if it's the case that 20 or 15 or 25 percent of what we now spend on medical care could be spent in other ways more effectively, or could not be spent at all, then it seems to me quite wrong to say that we are faced with the stark choice of either reducing the quantity of medical care or controlling its cost. In other words, there is a third way between the British example of severe service rationing in some areas and the American way of continued high spending on medical care. That third way is the Canadian route to cost containment — compatible with decent access to medical care — which I have already mentioned.

We have already looked at the difference in current expenditures in the two countries. Let us now examine in more detail the divergent patterns of the last 15 years that led to these differences.

During the period from 1950 to 1970, the experiences of the two countries in terms of percent of GNP spent on health and also in patterns of insurance expansion were broadly identical. In the United States, we experienced expansion of public insurance, aimed at selected groups of the population; for example, Medicare for the elderly, Medicaid for the poor, to some extent expansion of veterans' coverage. In Canada, they had public expan-

sion by type of service: government insurance for hospital care in the late '50s and for medical (physician) services in the late '60s.

The first element in our comparison is that Canada and the United States have had, in the post-war period, broadly similar experiences with medical care costs and with the expansion of insurance. Second, both societies can be understood as fragments of British political culture — the parliamentary model in Canada, a presidential model adaptation in the United States.

But interestingly enough, while our political traditions in some ways are both grafted from a British base, we also experience another significant similarity. Both America and Canada are largely immigrant societies.

> It is far from self-evident that American medical practices are the best starting points for assessing the performance of other health care systems.

In the post-war period, both societies have seen tremendous expansion of non-English groups. Chicago, for instance, is the second largest Polish city in the world, and Toronto has much the same degree of ethnic diversity. Something like a third of the Canadian provincial population comes from non-English-speaking backgrounds. So we find in both countries ethnic pluralism, British culture as the constitutional basis, and two societies that in their level of economic wealth are broadly comparable.

Most importantly, the medical care that is practiced, the medical education that's learned, and the type of hospitals that are operating are ones that both American and Canadian physicians recognize as broadly similar. They read the same journals, they have access to similar kinds of technology, and they have experienced, in the post-war period, the relentless growth of third-party financiers intervening in a world of professional autonomy.

These areas of similarity are the grounds for believing that, were we in the United States to try some of the cost-containment steps already taken in Canada, we would have reason to believe that we could experience similar results. This is not to claim that we would have identical experiences. It is, however, to say that there are enough similarities between Canada and the United States to make an investigation of their policy options directly relevant to our choices.

Let me leave you with a couple of considerations that ought to condition the way we think about our Canadian evidence. Twenty years ago, we made a promise to America's poor and America's old. We told them that, if they happened to be poor, other things might be a problem for them, but not medical care. Medicaid would bring them into the mainstream of American medicine. And we promised American senior citizens in the same year that, when they were old and sick, they would have access to American medical care in which their financial circumstance would not be the primary determinant of the care they received. Today, these promises are eroding before our eyes. In the wake of the runaway medical inflation of the past four years and in the presence of the overpowering importance of the federal budget deficit, we are fixated on ways by which we can cut back government programs. In the case of Medicare, that means only three choices: Either those costs are shifted back upon the elderly themselves, in which case their capacity to pay will, in part, determine their access; or those shifted costs are borne by other payers, like yourselves, in third-party payments; or older people with less means get different access to medical care than they have before.

Those are cruel choices; those are the real dilemmas of Medicare (and medical care) reform.

Bob Evans will tell you a story you haven't been told, one of a society which

> Physicians can maximize their own incomes by adopting an aggressive approach to medical treatment.

roughly 20 years ago said, not just to its elderly and its poor citizens but to all its citizens: Medical care is no longer going to be a market good; other things will continue to be market goods — cars, houses, clothing — but not medical care. In the case of medical care, access is going to be largely dependent on how sick you are rather than on your income, class or race. And Canada in those 20 years has managed to fulfill that promise while spending a fifth less of its GNP on medical care.

If I'm right — that it's a society similar enough to our own to learn from it — I think we ought to pay careful attention to its example when we consider the seeming dilemma of cost versus care.

Cost vs. Care: America's Health Care Dilemma Wrongly Considered

Part II: The Canadian Example

Robert Evans

Professor of Economics, University of British Columbia, Vancouver; leading Canadian health economist

Robert Evans' primary interests are in research and teaching in the economics of health care, and more generally in the public regulation of economic activity, particularly of "professional" occupations, and the sources of and responses to problems of market failure.

His research has covered hospital behavior and costs, analysis of particular programs in hospitals (such as day care surgery), physician price and output behavior, dental and pharmaceutical insurance and delivery systems, patterns and economic effects of occupational regulation, and determinants of regional variations in surgical utilization.

A consultant at various times to the governments of Canadian provinces, Canada, and the United States on matters of health research and policy, Mr. Evans has published numerous articles and books, the most recent of which is "Strained Mercy: The Economics of Canadian Health Care."

Those of you who have had any experience with people of the Canadian persuasion will know that the attitude that we have toward the United States is really quite schizophrenic. It's a constant source of complaint that Americans are quite ignorant about us, and pay no attention to us, and ignore us, and when they're studying health care or anything else spend all their time going off to Sweden and the United Kingdom and exotic places like that. It's always been a feeling of mine that perhaps it's just as well — that when you live next door to a society the size of the United States, benign neglect and total ignorance is probably the best thing you could hope for.

My excuse for intruding into an ongoing debate between two expatriate Minnesotans — Sen. Durenberger and my good friend and colleague, Ted Marmor — is that I bring the answer to the question which Sen. Durenberger raised. He — said the agenda of this conference was a discussion of the development in the United States of a health care system which would show improved access for people who needed health care, which would maintain and promote high quality care, which would guarantee at least a minimum level of both access and services for everybody, and which would do this within cost constraints or at least without continuously threatening to break whatever treasury constraints were placed on it. He said that was really a tall order and would take a great deal of time, effort and study for this conference.

It's therefore appropriate that we should have the Canadian experience put at the end because we feel the Canadian health care system meets most of those criteria. It has served to promote access and to shift the conditions of access from your wealth status. We now have a system which is more responsive to the health status of the people who come to get care from it. And we have a system which, over the last decade, has shown a remarkable stability of total health care costs with respect to the GNP.

You're going to see now a shift of emphasis here. Ted Marmor has emphasized the similarities between Canada and the United States. Canadians do tend to look at things a little differently. They define themselves as being like Americans in almost all respects, only not Americans.

In the same way, I think we need to reflect on the fact that our health care system is the outgrowth of a cultural tradition which is in some ways different from yours. We are probably as alike as any pair of societies that you could find on the globe. So, the logical place to look is Canada. And if it is true that we are prisoners of our own histories, and our perceptions of our histories and our social

philosophies are slightly different, it follows that you can't simply borrow our institutions off the shelf, even if you wanted to.

But it does not follow that you cannot learn from them. The key thing is to try to separate out from our description of our experience those things which represent the transportable pieces of information which can be applied, somehow, if you can find the appropriate means to do that within your own social and institutional context. As a Canadian I will inevitably overestimate those differences because that's the condition of our national survival and Ted Marmor, as a good manifest-destiny type, will tend to emphasize the similarities.

I should emphasize that that kind of learning goes both ways. One of the things that we have derived from U.S. experience is the frequently repeated, frequently tested, now many-years-old finding that how you pay physicians is the principal determinant of what hospital utilization rates are. The most recent randomized trial in *The New England Journal of Medicine* showed once again that if you put physicians in an American HMO, their patients will make about 40 percent less use of hospital days than they will if they are regular fee-for-service practitioners.

In Canada, we have relatively few HMOs or anything equivalent to them. We're probably not going to make a major institutional development along those lines. Nevertheless, the argument that we need, in order to protect the health of our population, even the levels of hospital care we have today is being clearly refuted.

I can't resist again going back to Senator Durenberger's comments because after having described what he thought were the conditions of an ideal system and after I just pointed out Canada appears to meet them he said, "The way the U.S. has got to go is not more regulation. That's obviously a mistake. We have to go to a more competitive system."

The funny part about Canada is that our relatively good results on a world scale are achieved through a pretty tightly regulated system. You can find worldwide examples of pretty crummy regulated systems, you can find examples of relatively good ones. I think we're a relatively good one. I don't think you can find any examples of a successful system along the lines that the senator was laying out.

That's not to say that it can't be done. It's not to say that you may not succeed in vaulting from relatively far back in the pack, organizationally, up to the cutting edge by trying something that nobody else has done. But you better be clear that what you are doing is taking a leap of faith into a world whose characteristics are known only hypothetically and whose strengths and weaknesses are argued about in the abstract. When you look at our experience you're looking at something which has been tested, in the case of medical insurance, over 15 years, in the case of hospital insurance, 25 years. We may not have the best system that we can imagine, but we do have something that works. We know it works. That's why it's worth drawing to your attention.

> We treat patients and consumers as equivalent concepts and they're not.

When we look at the process of determination of expenditures, the key variable that shows up most clearly is how our expenditure pattern is different from yours. We know that the difference in expenditure pattern is directly attributable to the funding mechanisms which we put in place over a period of years and which culminated in 1971.

We look at that difference and we are able to identify at least three reasons for linking that difference specifically to our funding mechanisms. In the pre-Medicare years we had essentially the same experience as you. When our funding mechanism was like yours, we had the same experience. When our funding mechanism was different, we had a different experience: for instance, where we went, not to socialized medicine, but to socialized insurance. In those components of our health-care sector where we didn't go to socialized insurance, our cost expense has continued to be similar to yours.

So, where it appears to us that you can achieve cost control without having to give up care — the bargain which is placed before you implicitly by so many commentators in the United States, the bargain which is "your money or your life" — that is, indeed, a false bargain as it has been throughout the ages. The reasons for making that bargain become clear when you look at cost patterns on a global sense because, as the national-income accountants remind us, a dollar of expenditure is always and by definition simultaneously a dollar of income. There's no way somebody can spend something without somebody else receiving it. I mean, you can burn the money, but that's a little different, that's not really considered expenditure.

That means that our cost containment, and your failure, is simultaneously our control of incomes and your failure to control incomes. Our success has come very largely because we have tended to focus on the channels through which those incomes flow rather than worrying a lot about the so-called demand side of the process. We think of utilization of health care — pricing, costs — as essentially determined by what's going on among providers and, if you can influence that, then you can control the system. Our experience has been that you can.

We feel that looking at the decision process among consumers is not a particularly constructive way to go. We haven't worried a lot about that. We don't get into a big flap about deductibles and coinsurance and so on. It is now formally part of our legislation that those are inappropriate and that provinces which permit them will be financially penalized. And it's generally regarded that such elaborations are neither necessary nor sufficient for cost control.

They're not necessary because we've done it without them and because your HMOs have done likewise. They are not sufficient because you are already the country with the highest degree of patient direct payment in the world, I believe, and you have not succeeded in controlling costs. Under those circumstances we feel

the appropriate thing to do is to focus on the behavior of providers. The argument that you can't constrain what providers do without simultaneously giving up something in mortality and morbidity is a way of throwing an intellectual screen around the patterns of income which providers receive. It's a way of saying if you control costs awful things are going to happen to you — you are going to die sooner, or you are going to live in discomfort, or great miseries will attend you.

That rests on two prior assumptions. One of them is the assumption that there is little or no pure waste in the system as you now have it. A corollary is: More is always better. The second is that the incomes that you pay people in this sector are appropriate — either ethically appropriate in that they are what people in that sector deserve, relative to everybody else, or economically appropriate in the sense that, if you don't pay those incomes, you won't get the people into the sector.

Those two fundamental principles are both called into question by the Canadian experience. Hell, they're not called into question, they're refuted. But the underlying notion that somehow health care is a commodity of which more is always better crops up again and again and again. We should be a little nervous about the opinions of all these economists because when we get sick we really don't want to know about cost control, but: "What can you do for me?"

It's an important insight and it's a weakness of economic analyses that we fail to take account of the fact that patients and citizens are very different people. We treat patients and consumers as equivalent concepts and they're not. The flaw in that line of argument is that more is not better. When I am sick, my call is not "do something for me, as much as you can," but, "help me." The response to that will often be: What you need is not as much as we can do.

There're two ways of addressing the question of how have we had this cost outcome.

One is, again, the accountant's way. We have had our sole impact on costs, in the area of physician services and hospital services. Those are the areas where we shifted to public insurance. We have had that impact by lowering the fee levels of physicians relative to their performance in the United States. There has been virtually no effect at all on actual utilization patterns by patients. The supply of physicians has not shrunk. Physicians are not bailing out of the country. It's generally agreed that we have a surplus of physicians. For the longer term, a serious stress point is set up by the fact that we are training physicians faster than the population is growing, and they are expecting to have access to hospitals but are not getting it. The key variable is that, over the past 10 years in the U.S., physicians have pushed their fees up about a percent and a half per year faster than the general price level. They continue to push their fees up faster than the general inflation rate. In Canada, the fees dropped off over that decade about two percent per year less fast than the rate of inflation.

So our cost-control performance in the physician sector has been a result of our control of fees. In other words, we've redistributed incomes. It's been as simple as that. The result has not been a mass bailout of physicians; we have a surplus. The result has not been that people don't want to go to medical schools anymore; we still have large quantities of excess demand of people trying to get in. There has been no problem in continuing to staff the industry, even though we have pushed price levels down through a negotiation process which consists of the provincial government in each province periodically negotiating a fee schedule with the medical association of that province.

So, we have found that controlling fee schedules does control overall costs. There's a body of opinion that says that can never work because physicians will always find a way to innovate around any fee-schedule restraint. That is not true. What is true is that a loosely drafted fee schedule can create those opportunities.

The second major area where we control costs in Canada has been in hospital budgets. Two-thirds of the difference between the United States and Canada arises through differences in the hospital sector. There's a sort of symmetry between the physicians and the hospitals. In physician services we have not controlled quantity. Physician supply continues to increase; utilization continues to increase. We've controlled price.

On the hospital side we've controlled quantity, and we've done that in two ways. We have controlled the supply of beds, and therefore the rate of hospitalization utilization in terms of bed-days per thousand and admissions per thousand, and so on. But also we have controlled the intensity of servicing within hospitals. In other words, the volume of services per patient-day — the man-hours, the applications of technological equipment, the supplies and services used up — all the things that go to make up a hospital episode. Those have been rising faster in the U.S. than they have in Canada.

There has also been an increase in the price of those services. Wages have gone up faster than general inflation levels in both countries; prices of other inputs have gone up faster in both countries. The difference has not been great. The big difference is that in the U.S. the real service intensity—the real number of things done to your basic patient—has gone up something like 3.7 percent per year over more than a decade. In Canada it's gone up 0.6 percent, which is almost nothing.

So, our constraints on hospitals have been relatively tight and have succeeded — not in preventing the dissemination of technology, but in forcing two things to happen. One, we have slowed down the rate of dissemination; we have something less than half the density of CAT scanners, for example, that you do. We have slowed it down, and we have not really applied sophisticated technological assessment to it. We haven't done all the good efficacy studies that an academic would like to see done. We haven't carefully identified the boundaries of application of the technique, but we have applied politically successful blunt instrument techniques which

> Life is definitely getting tougher for Canadian physicians.

amount to saying to the hospital, "Your budget next year is only going up X percent. Now, we understand you want to buy a new machine. Sure, go ahead. Where are you going to make your cuts? You find the money. You can do it. Furthermore, if you can come to us with a

really good story about why we should make a separate capital allocation for this machine, we might fund the machine and make an appropriate donation to support it. But if you go out and find a private donor to give you a machine you might very well find that we won't give you the operating funds. You'll have to cut programs somewhere else."

There has been an attempt to force new innovation to compete with old practice. The priorities are set within the clinical system. The priorities are set within the hospitals. They're set among the physicians. There has been little or no initiative by provincial governments to direct and manage the health care system.

Our cost control system has rested on controlling the quantity of equipment, services, manpower available in the hospital sector, and the price of physician services. There is a strategic variable which is not sufficiently appreciated in the health planning literature or among economists, and that variable is the doctor-to-bed ratio. It's not the population-to-bed ratio or the doctor-population ratio, it's the doctor-to-bed ratio. That ratio has been rising very rapidly in Canada. What that means is it's getting tougher and tougher for a doctor to get his patients into a bed, not because there are fewer beds per capita, but because there are more doctors.

Individual physicians who perceive our system as becoming increasingly underfunded are, from their perspective, dead right because the quantity of capital and labor supplied by the society through the hospital system to them in their individual practices is being cut down. Life is definitely getting tougher for Canadian physicians. Not only are they getting less fee growth than they feel is appropriate, they're also finding it harder and harder to get access to the tools of their trade. It's not as severe in Canada as it might be in the U.S. because about 50 percent of our physicians are still general practitioners. It's a deliberate policy of both the medical association and the government. But it is true that we are going to have increasing trouble maintaining quantity controls in one sector and price controls in the other sector. Maintaining the price controls is getting tougher and we're going to have to start thinking more seriously about it.

Whether anything will be done is another question. There is a recently leaked Federal-Provincial Manpower Committee report saying that we've got to bite the bullet and close some medical schools. We've got to do that if we're not going to have increasing pressure and friction developing on this imbalance — this interface between physician supply and the hospitals.

Our future problems are problems on the provider side. The usual story that you get is that our experience has to break down because our population is getting older. We're going to need more services. The march of technology is constantly expanding the efficacious interventions, so, even if we're cutting fat out of our system now or have been in the past, eventually we will find ourselves on the same path that the United States is, facing continuous escalation. If the hard choices — the grim tradeoffs between "your money or your life" — aren't on us now, they will be soon.

That may be so, but at least we'll hit those choices 2 percent below where you are, so we're already many billions of dollars ahead. Expenditure delayed is expenditure denied . . . or something like that.

There's more to the story than that. We've done the estimates of the impact of aging on our costs. Some people in the United States have started to do that. You take a detailed age/sex breakdown of utilization and you cross it with a projection of the population. You see what happens to the utilization of the average member of society as that person ages and experiences the higher-use rates associated with age. That's a fairly straightforward mechanical computation. Indeed, with the march of microcomputers it's the sort of thing you can do in your office, and it's quite neat.

It shows the impact of aging has been grossly overrated. Over the long term, it is very important. It's like a glacier: It doesn't move much this year, and it doesn't move much next year but, if it keeps on moving for 50 years, it's going to transform the landscape. In any one year, the impact of aging on our demand for physician services or our utilization of physician services is 0.25 percent per year. That is awfully close to zip. It compares with an increase of physician supply of 1.5 percent per year.

Impact on acute-care hospitals? A bit more: 0.9 percent per year, well within normal economic growth rates.

Home care? Long-term care for the elderly? Those such things? Faster, no question about it.

But overall, the impact of aging on our costs should be somewhere a little below 1 percent per year, which is easy to maintain in a normally growing economy.

The utilization patterns of the aged are changing. There are more and more elderly people around, and the health-care system is reacting to them in a different way. They are much more intensively serviced.

> The impact of aging has been grossly overrated.

There are a couple of different ways of looking at that. One way is to say, "Our outreach, our technology is improving. We are now able to do more things for these people. We can replace the knees — we can replace the hip. There's just much more scope for efficacious intervention now."

There's another, more cynical, way of looking at it. As the demand for hospital-based income expands, the corresponding expenditures have to be found somewhere. It's a lot easier to generate expenditures on the elderly because there's always something wrong.

Furthermore, technology is expanding the opportunities for expensive interventions, but there is nothing inherent that says it has to expand costs. There are lots of examples of technology holding down costs. But technology doesn't fall from the sky. Technology — change — is the outcome of conscious decisions by real people and organizations to invest time, effort, energy and intelligence into finding out new things. They do this because they expect to make some money by doing it. If

your system is such that you reward people who develop cost-expanding technologies and discourage people who develop cost-reducing technologies you should not be terribly surprised if you find a trend of ever-cost-expanding technologies, which is virtually unique to health care.

In all other industries, people think technology lowers costs. Why does it keep pushing them up in health care? It's quite simple. You have a system of reimbursement, a system of incentives which encourages that kind of a dimension.

If you change the pattern of incentives you will get a different, and a less serious, technological problem over the long term. That is a statement of faith. It's happened in other industries.

The one thing you can be sure of is that the current pattern of application tends to be almost universally over-applied. The tendency is to take a technology that works in a narrow area, constantly expand the penumbra of doubtful utilizations, and then take the attitude that the observed maximum scope of utilization must be right.

There is no necessary reason to believe that our system has to come unstuck. The political will is there to maintain it. Last year, the Canada Health Act was passed — assembling, revising, and bringing up to date all of our hospital and medical insurance legislation. In particular, it took action to suppress the beginning growth of direct billing of patients by physicians. So, we don't think that there are either technological reasons why it's got to come unstuck or that the phenomenon of aging is large enough to do it for us.

I don't think we've been nearly energetic enough in assembling evidence. We have been sufficiently successful in running our system that it has undercut the kind of energy that might otherwise have gone into better evaluation of what we do. You people evaluate your system a lot more competently, a lot more extensively than we evaluate ours.

The difference is, of course, that you don't do anything with the information. We have a tendency to act — and we have been a little bit successful. It's hard to find a political constituency for improving the direct management of the health care system. I think that will come. It will probably come faster here. It may well be one of the crowning ironies of our experience that 1) we put in the system that was intended to expand utilization and access — you, when you built your insurance system, were terribly worried about controlling overuse, 2) we have turned out to have the system that is one of the most successful in the world in controlling costs — yours is one of the least. This was not part of either of our intentions.

Furthermore, with the radical changes that are under way in your system you may well find that 10 years from now fee-for-service and traditional medicine are distinctly in the minority here, where they are defended within Canada. That would be interesting for the people in the medical profession who fought against the introduction of our system to find that it had become the last, best defense for fee-for-service left on the continent of North America.

The final message that I want to leave is that our experience tells us that the outcomes which your system experiences are ultimately results of the effectiveness of your institutions, your ability to assemble constituencies. They are not forced on you by your stars. You are not locked into some sort of phony technological determinism. You'll notice that when you finally get past the technological determinism you have room to fly. The key point is whether you end up with a better managed system or a system that eventually throws overboard your poor, which we sometimes think you're in the process of doing: "If there's no way of funding the existing system, if we're going to have to ration anyway, why not ration by price? Why don't we chuck over the people who can't pay? We've got to chuck over somebody, it might as well be them, and not us."

You can see some signs of that, that there is no other option possible. Our experience says there is another option. If you fail, it's an institutional failure, not a technological constraint imposed on you by the nature of the universe. If your political system is simply unable to respond to the demands of supplying effective cost control and humane medical care, then I can only remind you that you people had the revolution, not us. It's not our fault.

You are not locked into some sort of phony technological determinism.

Q It sounds like, on the one hand, doctor's fees in Canada are being held in check — or lowered — and the physicians' access to hospital beds is being restricted. On the other hand, the enrollment in medical schools is very good and no doctors are emigrating out of the country. Could you comment more on the motivations of Canadian doctors?

A Evans. First of all, it's not true that no doctors are emigrating, but the rate of emigration is now back about where it was in the '50s and '60s. Actually, there was a little climb in the early '80s, but it's gone down again now, and it's more or less holding level in real terms. Physicians are still the most highly paid occupational group in Canada by a fairly comfortable margin. There's a lot of room for squeezing physicians' fees. You get a lot of screaming, you get a lot of political backlash; it's not easy. But they don't leave the field, and they keep coming into it because it's still a well-paying field. I think what that tells you is that you've got an enormous amount of room to maneuver in this area.

There are one or two other things I should put in here. We have state supported medical schools across the board. There's no such thing as a non-state supported university in Canada, so the entry fees are substantially lower. The interns' and residents' salaries are now much better than they were a generation ago. So, the entry costs at the front end are relatively much lower than they are in the U.S.

Q One of the major differences between the Canadian and the U.S. culture and socio-political system might be the medical-legal system and the issue of malpractice. Would either of you comment on the possible economic significance of malpractice on health care costs, comparing the two countries?

A Marmor. The malpractice experience and the legal system in which it's cast is different in the U.S. and Canada. An example of that is a conversation I had last year with an orthopedic surgeon from Toronto who was complaining that his malpractice bill was $3,000 that year, up from $2,500. For those of you who know about that comparative experience you can see how different it is.

The reasons are complicated, but they have to do with the fact that the loser in a malpractice battle in Canada pays the cost of the other party — which is one means of reducing the incentives for frivolous suits.

Second, the Canadian Medical Association has an overall policy of pursuing every malpractice suit to the end, so that there is little encouragement for settlement.

Third, most of the malpractice suits in Canada are held in front of judges, not juries. Three institutional reasons conspire to produce a malpractice picture very different from the United States. I might add it's very similar to that of Great Britain. So it can't be used as a way of differentiating the experience of Canada from that of Britain. Evans. The costs are not uniformly assigned to the defendant, but the judge has the option of doing so. The judicial process distinguishes between the frivolous and the reasonable, but failed, suit.

Q Professor Marmor, given our views of socialism and our tendency to view socialized insurance as socialized medicine, could you speculate on whether you think we will follow the Canadian example?

A We have two courses of action. One is that we will continue to experiment with different ways of organizing American medicine. We will continue to experience relatively high rates of inflation in the health care sector, as against other sectors. We will continue to experience pressure on federal programs — Medicare and Medicaid — as the budget deficit forces government programs to try to find ways to control their program costs while not controlling overall costs. That picture will produce by the late 1980s and early 1990s a situation much like American medicine was like in the 1960s — great differences in access by region and class. I think that is the most likely scenario, as long as Ronald Reagan is President and as long as the annual budget deficits are in the $150 billion to $200 billion range.

The other option is that American states will continue to experiment with ways of organizing their regulation of medical care costs on the model of New Jersey, Maryland, New York, Connecticut and Massachusetts. If that's the case and political entrepreneurs at the state level discover that while coping with the rising cost of medical care they can make a reputation for doing both good and well, then we may inch toward a Canadian situation in which provincial — in this case, state — initiatives build up slowly to where we have national health insurance.

Let me give you an example how that might happen. If we follow the example of New Jersey, we will have an all-payer system of hospital finance which provides a pool of hospital resources from all those who pay: Prudential, Blue Cross, Blue Shield, Medicare and Medicaid. Those hospital services are used across the state. When a non-insured patient comes in, that patient is paid out of that pool and you have, in effect, universal hospital insurance in New Jersey. I think it's a lower-probability likelihood than the first one I suggested, but it's possible.

The Previous Public Affairs Conferences

March 1984

The American High School: Educating for Tomorrow

Speakers: Terrel Bell, former U.S. Secretary of Education; Patrick L. Daly, Vice President, American Federation of Teachers; Chester E. Finn, Jr., Professor of Education and Public Policy, Vanderbilt University; Noritake Kobayashi, Professor and former Director, Keio University Graduate School of Business, Tokyo; Lorraine Monroe, Chief of Instruction, New York City Schools; John Ratte, headmaster of the Loomis Chaffee School, Windsor, Conn.; Diane Ravitch, educational historian and author of "The Troubled Crusade: American Education, 1945-1980"; Billy R. Reagan, General Superintendent of Schools, Houston Independent School District; John Sculley, President and Chief Executive Officer, Apple Computer, Inc.; Theodore R. Sizer, Chairperson, Department of Education, Brown University; Edith Weiner, Strategic Trend Analyst and President, Weiner, Eldrich and Brown, Inc.

November/December 1982

Who Will Save the American City?

Speakers: The Rev. Ralph Abernathy, poor people's advocate and civil rights activist; Thomas R. Donahue, secretary-treasurer of the AFL-CIO National Council; Anthony Downs, economist and senior fellow with the Brookings Institution; William H. Hudnut III, mayor of Indianapolis and past president of the National League of Cities; Samuel R. Pierce, Jr., secretary of the Department of Housing and Urban Development; William Raspberry, *Washington Post* columnist; James W. Rouse, urban planner and developer; James Q. Wilson, former director of the Harvard/MIT Center for Urban Studies and professor of Political Science, Harvard University; Coleman Young, mayor of Detroit and president of the U.S. Conference of Mayors.

March 1981

Mass Media and the Elections: Who Dominates American Politics?

Speakers: the Honorable John Anderson, independent candidate for President; James David Barber, Presidential scholar, author; John Terrence Dolan, chairman, National Conservative Political Action Committee; Hubert Feichtbauer, editor, *Die Furche*, Vienna, Austria; Jack Germond, political editor-columnist for *The Washington Star*; the Honorable Walter F. Mondale, former Vice President of the United States; Richard Scammon, director, Elections Research Center; the Honorable Claudine Schneider (R-RI); Sander Vanocur, ABC News diplomatic correspondent; Linda Wertheimer, chief political correspondent, National Public Radio.

March 1980

The American Political System: Is It Coping with the Problems of Our Society?

Speakers: Amitai Etzioni, White House advisor and sociologist; Fred Friendly, former president, CBS News; John Gardner, founder of Common Cause; Godfrey Hodgson, British television commentator; Vernon Jordan, president, National Urban League; Richard Neustadt, public administration professor, Harvard University; Eileen Shanahan, *Washington Star* editor; Harold Williams, chairman, Securities and Exchange Commission; Daniel Yankelovich, president, Yankelovich, Skelly & White; Adam Yarmolinsky, former Defense Department lawyer.

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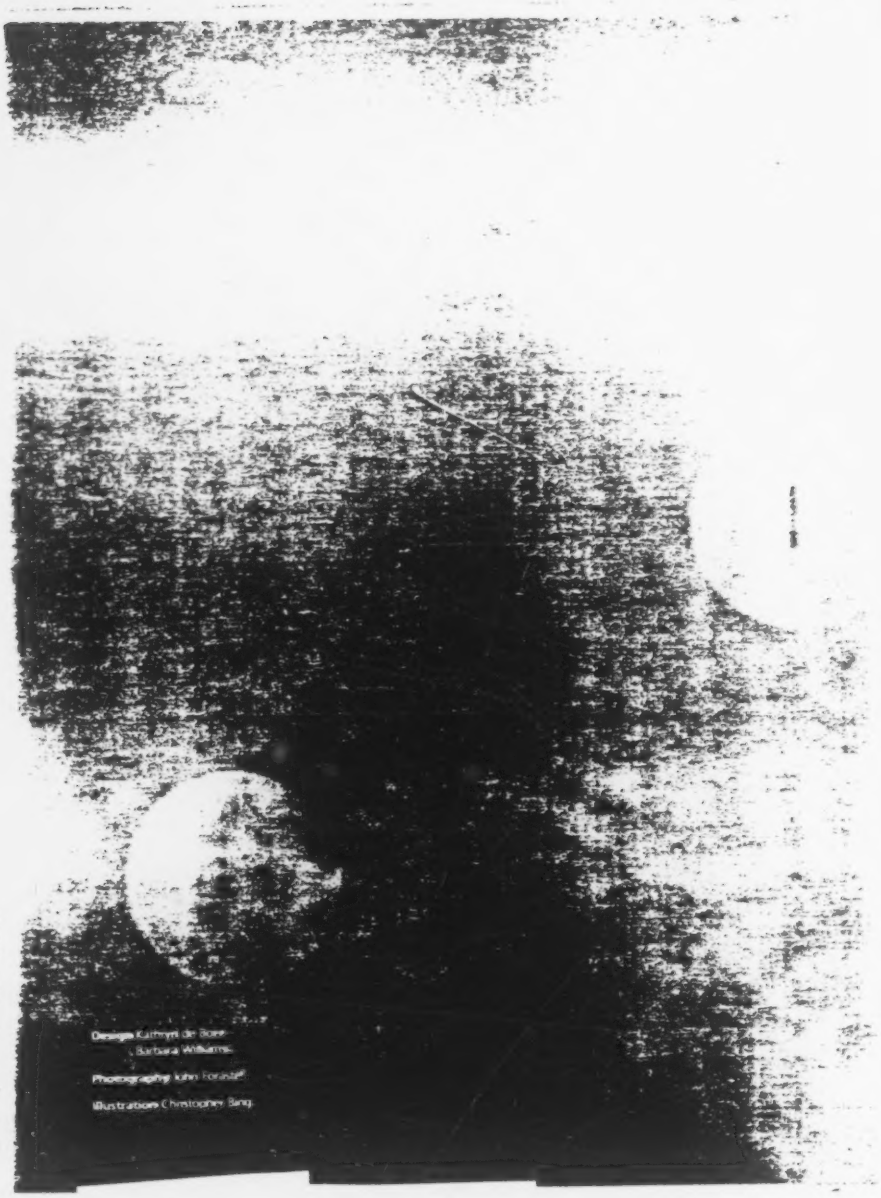
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CORNER CONGRESS - Health Spec - Pirrana Press 1/9 Mission

I'm going to talk a little bit about how a senator from from Minnesota who did not expect to be a U.S. Senator came along in 1979, rode a wave of cutting spending, cutting taxes, balancing the budget to the country's largest deficit under the most uncertain economic times and revolution of health care which did not exist when we were elected to political office. I'm going to do that courtesy of talking about Pirrana Press which was good enough a year ago to permit you to view similar crazy ideas that I've had on the subject of national security. A book called Neither Madmen nor Messiah which is appropriate of the characterization of the place which I may be called before the evening is out which is the exuse of an election, that is the collection of 435 of us gathered oround the capitol every day for the business of you as your elective public servants. This was an effort to say that somebody elected to the U.S. Senate at that age of 42 or 43 from a State like Minnesota an office that he never aspired to hold office, while an office that he treasures is not an office that he had to hold but if somebody wants to hold began to think in unconventional terms about the subject of cutting spending and cutting taxes what they really mean. So I'm going to take a few minutes tonight to talk to you in a larger context about what's going on in this country and ask you to make a contribution to resolving the problem of this country during the course of questions and answers tonight. I hold this up only becuase the book is not telling you what we should (laughter) and because you will all criticize the fact that when we get to

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Gramm-Rudman or whatever we get to we will be cutting deeply into Medicare because we have found ourselves unable to cut deeply or at all into defense spending. This was a way to say that if we readjusted our principles we would also readjust the way we spend money. In this book, as my friend from 3M and other companies will tell you, that they read this from cover to cover as they will tell you this then asks the question like is it a fact that we are from the Soviet Union. Be that the case if you were to structure national security policy you do not security policy somewhat differently from a content would you not also on the assumption that you are not going to have Soviet troops attack you on your island do not expect that you might do battle on If so, what does that tell you about where you put your resources? It should tell you that you would put your resources in the Navy, Air Force I'd go through another set of principles that are very similar to that and suggest that using principles is a much better way to get a national security policy than using the advice the last guy that holds this job you now hold gives you as he leaves office. In other words, incremental approach. Having said that, I am hoping everybody has told or heard, I know I'm not impressing you with your office off the table let me suggest to you that a lot of the things we have heard today can be approached in some set of principles. In fact I would suggest to you that the only way this country is going to solve the problem of a $2 trillion deficit that grew last year by $212 billion is for us to start dealing in terms of principles. If we continue to deal in simplistic ways like cutting spending and cutting taxes is a good way to fix the

economy or cutting tax rates to 35% or 33% is a good way to fix the economy or a good way to concentrate on taxes. We aren't going to make it because those are the principles that got us into the $3 trillion deficit
or the $212 billion add-on last year. I have a whole other speech that I first gave in 1979 or 80 when I got here which is about health policy which I can't remember anymore, but it was entitled "The 8 Beautitudes" and it was a set of 8 principles of which anybody who wants to change the way we deliver health care in America might preface that change and it has some principles like government ought to fostor choice but not dictate its choice. How do those stand for principles? And there are 8 of them that in effect a few of use who were involved in consumer choice of health care thought we had premised this evolution that is taking place in health care delivery today. I will suggest to you if we have time that we do the same thing for tax reform rather than giving 35%, 33%, or 2 thousand dollars as our principles for tax reform we could use another set of principles that would get us the tax reform without doing damage to those tax expenditures which are not defended by our in Congress. But on the subject of health care cuz you're all in that business and since I'm told you have a big international conference coming up in 1987 which I figure I will be involved in reflying Charles Lindberg's route to Paris and we will all be celebrating the 200th anniversary of the Constitution by taking it apart or amending it in various ways, I'm sure. Let me try to build a little framework around what you're doing and where we're going in the health policy area, and if you'd like to branch out in those services feel free to. As I said what we are doing

today is premised on the theory of consumer choice and prefaced on the theory that if in the last 30 years, that is the adult years of my generation, I had been permitted a choice between staying health or getting sick I would have chosen health over illness. And had I done that I don't think the nation's health care bill would have been $400 or $400+ billion today; it would have been substantially less. If I had that same opportunity with regard to my housing to choose only the kind of housing I could afford and actually pay for it rather than been given my housing I suspect the average house/home in America today would not cost $86,000. My generation is the beneficiary of the will that came out of my parents' generation with respect to all these principles. My parents had me in 1934 and that was the year in which I was all they could afford to have. And they, like some of your parents, swore that when they got political power in this country they would see to it that I would never have to or we would never have to (laughter) that we would never have to live through what they lived through in the 30's. They did two things--one good one not so good. They were all in the game of having or not being denied. The good thing that they did which I hope we hit onto, guaranteed that regardless of your race or your creed or your color or your handicap or your sex you would have the same right and opportunity to what this country delivers for all of us, the majority of its citizens that everybody else has. So when the Hubert Humphreys and that whole generation, my parents' generation, came to political power in this country, they did things like civil rights and occupational health and safety and a variety of things that said "My god, it shouldn't make a difference where you came from, you oughta have

an equal opportunity." In other words you may not all be alike, but at least you oughta have an equal opportunity. And they put that into law and that law is sometimes in question now that Ed Meese is the Attorney General, but the reality is I think that's the good thing. They said you ought to have the right to equal rights, to equal accommodations, you ought to have the right not to sit in the back of the bus, or you ought to have the right to be president of the bank not the teller if you're a woman, cashier or whatever the case may be. And that's the good news. The not so good I would suggest comes in all the other, the needs, the way we satisfy our needs in which they decided that the way to provide a shelter or a health care or a lot of other things was to create having it without paying for it so whether you look at health care or however you look at how you purchase housing. I now own a $350,000 home in McLain, VA which I paid $187,000 for when I was elected to U.S. Senate at that time. On my way to that I bought a Lake Harriet home in Minneapolis, for you Minnesotans that are here. I bought in 1971 a real nice home on Lake Harriet, downtown Minneapolis for $77,000. I sold that in 1978, seven years later, the same house, one coat of paint, in fact all I did was paint the shutters. I sold it for $249,000. That house, the previous house I had bought for $30,000 and sold for $55,000 and the one prior to that was my first home that I had paid $10,000 for and sold for $20,000. What did all of that cost? Well in addition to the $350,000 home in McLain I also have a $60,000 condominium in downtown Minneapolis. Those are my two homes, my two major assets and my two savings accounts--what do they cost? They cost a lot of taxes. They cost me the first $500 that I paid on the first home. That's all. Because of that

first home, I paid $500 down, I had 30 years to pay, 4 1/2% interest and that was 1959-1960. That's when my parents' generation said we want everybody to own a home. So they 3 houses. They said for $500 you can all own a home. So everybody who wanted to own a $500 home, stood up with their $500 and as we look across the country, there were twice as many $500 buildings be raised as there were homes. So what happened to the price, the value, the price not the value, the price of all the homes that existed in 1959? They all went up didn't they and the demand exceeded supply by god the price goes up, what happened to the carpenter's wages, what happened to the cost of plywood and insulation, the whole smear? I don't have to lecture you to damnation on that subject because we are all beneficiaries of having it without paying for it. The net result is that we all own $50,000 homes that are worth $350,000 be that covered in savings accounts, we educate our children on them, we can do a whole lot of things in them. But, we are our children that is a fact for 93-94% of the people. That's the price we pay. Some people are able to keep that by reducing the prices substantially. In Appleton, Minnesota for example, a small community in western Minnesota, there are 42 homes that have been on the market now for a community of 4000 people who 42 homes on the market for over a year. So those $40 or $50,000 homes in Appletown aren't worth $10,000. We probably created that one when we broke that one by breaking the fact of farmland values. For a $3500/acre of farmland in Minnesota years ago today is worth $600. And the price that the farmer gets for his product is less than it was 4 years ago so by knocking down the price and the value of their productive asset we've driven down

the demand to live in Appleton so nobody wants to buy the homes. We've broke the fact of homes in Appleton. For those of you who don't want to live in Appleton but in St. Paul/ Minneapolis you got another problem like in McLain, Va. You're priced out of the market. What do we do in health care? THe very same thing. We took a good thing--group health insurance provided first in 1904 by Sears Robuck one of them was the first company to start group health insurance in 1904. In 1954, 50 years later we took that wonderful invention and we blasted it with the Internal Revenue Code and we said if it's good for Sears Robuck it's good for the public. So we said we'd give the employer the reduction for the premiums and we will not count it as income for the employee." What happened after 1954? Everybody wanted health insurance and we destroyed insurance. And we destroyed health. When we made the commodity free we converted it from health-player to sick-player, and we lost the right to use the word insurance cuz it was no longer insurance. I went to work for the H.B. Fuller Company in St. Paul for Elmer Anderson, former governor, in 1970. They, like everybody my age or for that period, I was given my health insurance plan. I never looked at it because I knew it was free. All I had to do was put up and went home. My generation was raised to believe that it was better to go to a hospital than it is to stay home. The nurse took much better care of you than your mother or your wife. The boss paid you to go to the hospital. You didn't have to work to go to the hospital. All of your friends came and said nice things about you if you were in the hospital. Nobody even sent you flowers if you stayed home or of you stayed well. My generation was taught to believe that if we

drove without safety restraints or motorcycles without helmets it was ok because somebody would pick us up and take us to the hospital. We were taught to smoke, I mean encouraged to smoke, not just tobacco subsidies and that group, but by that fact that Barnie Clark who did smoke 2 1/2 packs a day for 25 years was able to go and get the first artificial heart that extended life by 4 months at the expense of taxpayers. This reward was not unusual. That's them, my generation, our generation's experience, so we wonder what do you do about a $400 billion deficit? Well the first thing we gotta do is blame somebody else. Barnie Clark, if he lived, would not blame himself for using an artificial heart. So you have to blame somebody else. That is the period we've all been through, maybe we're still part of it, I'm not sure, but it's a period of time of which you say, blame the doctor, I mean you know, we got too many of them to begin with. Their all , etc. etc. etc. blame the doctor, then why not blame the hospital? We got too many of them too. They charge you. But why? Why? Because everybody stood up with their free health insurance plans and said I don't wanta be sick. Is it any wonder we have too many doctors, we have too many specialists, we have too many medical educations letting people down, you know, I am the specialist of that, I'm not knocking it, that is just the reality. But that's how we got the no brand design of the heart of optomology to spend 5 years on top of some basic medical education to get to the finer points of the eyes so they could make optomologists for $20,000 a year (laughter) I told you about the $77,000 house I sold for $249,000. We put a little ad in the paper. Two people showed up at the door a 1/2 hour earlier before the showing. One was a

lawyer, one was an optomologist. This is a true story. We took them upon a tour of the house with spouses. They were both males, and with their spouses we went through the house, then we sat in the livingroom and said are there any more questions. The lawyer said, I'd like to see the house again. So off went the lawyer and the spouse to look at the house again. The optomologist said, where do I sign? (laughter) Like that he bought a $249,000, so I assume he was doing very well. But do I blame the optomologist? Of course, not. I don't blame the hospital for taking us in on Friday, operating on us Tuesday and it gives us another week and we'ed be alive We just don't don't do that. For those of us who believe in consumer choice, start on that premise that we've had all the incentives wrong for this generation and if we changed those incentives some good things will happen. And so we're changing the incentives and some good things are happening and potentially not so good things are happening and that's why you people should be part of this process of health care reform. The good thing that obviously would happen is that if I had a choice first of staying healthy or getting sick, if I could find a reward of staying healthy, that's right we have HMOs and some of those other kind of plans where the incentives of prepaid plans where people are put in risk in taking care of certain procedures for a period of time, the theory is I'll try and keep you healthy and the surface of being ill they'll try to keep you healthy. If you were to buy life insurance, health insurance, and so forth policies that really were truly actually wagered against your life style and bad habits wouldn't that be wonderful but we don't smoke cigarettes or something that's about

the amount of courage have today but if we didn't, wouldn't that be great. So we're starting on the premise that people would choose to stay healthy if they could see that this side of good that they were personally rewarded and they're doing it. We start on the assumption that people have a choice in health plans but they would over time make wise choices. The health plan would have choices of doctors and hospitals and so forth and we would have ourselves a little revolution that's going on right now. So in order to get that going we change Medicare payment system to the prospective system. And it's really going and where it will end nobody really knows. The objective from our standpoint is to prospectively price everything that we pay for on behalf of our Medicare beneficiaries. That includes the doctors, that includes nurses, facilities, hospice, just about anything else you can think of. I originally thought it could be one payment given to the doctor let the doctor order up what you need and let the doctor make the decision between the facilities but it looks like that's a little more difficult to come by, but the thrust is to prospectively price all of these goods that we buy. But ultimately, we won't be in the arguments of concern because our ultimate is to have everybody in this country to have the opportunity to buy a health plan with the choices of health plans that exist in their community, health plans that are truly competitive with each other on the basis of price, benefits and services that they deliver. And everyone in America, literally everyone in America should have that kind of option. If they're poor their health plan might be payed for at least in cash or part by the government through some kind of individual care

program. If they're employed that shouldn't be offered by the employer. If they're self-employed the same kind of choce but with the similar tax deduction that employers get now. And if you're on Medicare, you should have that same choice. I guess I see it in the Twin Cities for sure in the next few years when you can go from with the same health plan if you want but every year you'll get the choice of changing plans but you don't have to have one thing if your're poor, another thing if you at work, a third thing if you're retired. We got to be able to retire people on the same choice of health plans they had when they were at work. And if 3M wants to pay part of the retiree's health plan well then 3M pays part of it, Medicare pays part of it, and then the beneficiary should then pay part of it too. But only one plan, not the 3M plan, and the Medicare plan, and then some wraparound to supplement Medicare, then we're wasting all our money, just one choice plan. And so, as you see us move into what's called competitive medical plans that's the area which we're headed. Behind that you were involved in things like graduate medical education, and this year I'm pleased to say we have made a commitment for Medicare to finance a good part of graduate medical education. We haven't gone as far in graduate medical education as some specialists would like us to go, but at least we made the commitment. We could have pulled out of it entirely and said hell, if you want medical education you pay for it. We're not going to pay for it. We're going to pay for services. You get education, but we think the education of physicians is an important part of service that we have, so we have outpatient surgery, you know what we have on the Senate side in terms from everything from cataract surgery to 150

of these procedures today that we know of that don't have to be done on an inpatient basis in an hospital or compensation for that. If we don't get it done this year we'll probably do it next year. Gramm-Rudman will force us to go that way but your best interest is to try to find a good way to come up with that reimbursement system before we just take the money away from the doctors or take it away from manufacturers. On the part of the manufacturers, the things that bothers us the most when we deal with the prospective payment is that we were going to curve ingenuity and innovation. Because if you inverse those incentives too quickly you take away too much too fast--what do you do to innovation? And particularly, when you set up this basically regulatory DRG system which puts the same price on every procedure, what do you do to the next invention that comes along that costs more to put in but actually reduces the cost of federal so we knew that was a problem and we're still struggling with it. Thanks to the help of industrial manufacturers, associations and various members that have been working for a year to come up with something. And I think we just about got it now. I still don't like it a lot because it looks kind of regulatory, and I don't want to make it regulatory, but we don't have a lot of choices in this field. And I think we will be introducing something before we go home at Christmas this year. Look at it, shoot at it, do anything you want, but I would suggest to those of you who are the manufacturers that you give it attention and try to come to some consensus for the next couple or 3 months so when we do reconciliation in 1986 the first Gramm-Rudman. If you are there to say we've got a positive way to reduce over the next 5 years the spending in the

Medicare at the same time get yourselves some reform out of this system.

I have talked long enough on the subject I took on tonight. I have a hard time stopping, but if you all want to eat dinner, if there is another course to be served, you can probably bring it in here, (if that's what that guy is doing out there). I would stand here above the quiet clutter of plates, I would resopnd to any questions that stimulate anything I've said here in that vast area I have touched on at all which is all the other things we're doing right now.

Questions

Do you think Gramm-Rudman can stand a chance of taking us off this track in health care delivery and paying for it on an annual basis and really projecting that people to vote for those things that may not be paid off in two years but.....

A. The danger in Gramm-Rudman is that it won't , it's esentially anti-reformest because it is premised on spending is bad. And in this reform area mostly you gotta spend money to make money so it is essentially anti-reformest, but everything we're doing in this area is reformest. The DRG system for hospitals is if you want to expand the doctors you're going to have to have some kind of index of payment to keep them up with some kind of medical crisis so practically everything we do is reformest. And the graduate medical.....

Q. Given the Gramm-Rudman, and manufacturers The PDA and DRG are dichotemies in themselves. Given the Gramm-Rudman, is there nothing in the budget to help the PDA take care of the medical devices to get through the agencies. It's now taken 15 months.....Gramm-Rudman.....I'm the last person who wants to sell the PDA. The contradiction is so obvious.

A. I guess I ..... the Medical Public Health Association they have a different, but similar problem. You get into health prevention and that's an area we've got..... I got to educate you against the dangers of smoking in order to save money out there some place.....what happens to your heart, your lungs, and so forth. When there's a woman pregnant for the first time that doesn't know about alcohol and smoking, I've got to spend a little money on her in order that she can carry that baby to full term whether than delivering the baby at seven months and then spend approximately $5000 a day to try and save that child. I told them what I believe and that is the federal programs that are federal spending are probably going to be much better off than federal programs that are state spending or entitling the grant to someone else. That the Center of Disease Control in Atlanta or the PDA or those people are going to get more support in both the appropriations process and reconciliation process than is something like internal grant.....That is

much easier .....or Medicare payments to doctors and hospitals. We tried to keep Medicare in category I of Gramm-Rudman where only the index parts could be taxed whether than moving it down into part II. Or 54-43 I believe because Medicare payments simply as payments of doctors and hospitals. Doctors and hospitals don't need the money anyway so you know that's how they do this. That is my assessment of where the cuts will hurt the most. They'll hurt the most on federal money transferred to state and local governments for health purposes. The second most relieved will be payments to provide records for survivors; the one hurt the least will be the money spent by the FDA or NIH or somebody else - that's much easier....

Q. Would you have a balance in mind that expands the foreign policy issues and the economic issues and in a sense you speak for a larger whole rather than specific issues. One of the best things happening in America's media is .....the thing that comes across in that program is one gets asked the questions and one answers.....at the time. What happens is .....what is happening to me and what I perceive is that everytime is that every senator in most of the country has lost control of the process the government and they are called, we can't pass the balanced budget and if you heard Rudman and Hollings the other night on that program, they said, look we lost control we're all.....careening down the side of the mountain and we're trying to regain control. I see Gramm-Rudman as I've taken the pledge on Sunday morning, bad night last night, and somehow there isn't a big picture sense of

where we are, where we're going and what the future is and the longer you grip, the more you use up that precious option of the percentage of fixed payments to the budget and people are talking about that but they're and there are people like that .....how much longer can people go through?

A. That is a well-stated analysis. I guess it takes somebody from out of town to say that. But you've done a fantastic job of stating the problem in a way that some of us.....the frustration of looking at this deficit .....is only a matter of to be cut from this level and restrained from another level meaning revenue. I was elected in Minnesota not by..... or Democrats but by people who are a different scheme of people.....but people in my state are not the kind of people that I would refer to as being against Gramm-Rudman ....probably that they know in terms .....or costs too much and they didn't send me down here just to balance the budget or get rid of government, they sent me down to change the way of doing business, that's what they sent me to do and so I'm a natural reformest and I found it very difficult to be living in an environment where because the drum-beat is always against government, the reformest want to use government differently is difficult to ..... I mean, watch Ronald Reagan on TV, I mean he will feed that side of you that believes government never.....and we oughta get rid of it. And if that's the notion, then we'll continue to go along with the Gramm-Rudman problem, don't take anymore taxes from the people cuz you'll be giving politicians more money and they'll find a way to spend it. That theory is probably still the theory that .....is the

theory that was appropriate to get the place turned around, it was appropriate for the first four Reagan years, it was stated by a person that can state it better than anyone else, Ronald Reagan, but it is not appropriate for now and beyond. And when we are too in debt we need another theory or operation for getting rid of the government and that's why in the area of , to get back to principles, I have found this notion of consumer choice works really well in a lot of areas. It's applicable in education, already adopted in higher education, should probably be adopted in elementary and secondary edcuation. I'm using it now in Intelligence. We're developing a long-term national intelligence strategy by advising the people in the national security operations between consumers and producers. Instead of everybody always complaining that the CIA doesn't deliver this and the CIA doesn't deliver that, we're teaching the consumers in saying, Hey let when was the last time you were precise in what you ordered from the Intelligence? So there's something worthwhile in a philosophy, not a philosophy of government so much as a philosophy of public service. How you should use public service, whether it's health, education, transportation, energy, whatever it is. Having a philosophy that occasionally permits the government to play some role rather than play you gotta have a basic theory for the actual delivery of public service. That's sort of what is lacking in the system today. That's the consensus on that.

Can you expand somewhat on your comments about what you're proposing in the system economics and.....

A. I can be clearly precise.....(laughter) the premise I guess.....shot down last year was that all you people take your products to the FDA, they'll decide upon a competition basis, you know, whose product is going to try out, and that's scounds too much like a livestock auction, so we're now into the technology diffusion iniative in which we're going to promote the purchase by .....that do medical technologies that are quality enhancing but also cost increasing. The actual required providers that use subject technologies to collect clinical financial data that can use budget cuts use an ultimate medicare coverage decisions on those that use technolgy. How do you qualify? You have to be a truly new technology. You have to have premarket approval by the FDA but not yet accepted for for coverage. Costs the DRG payments, a result of financial.....manufacturers develop new, I don't the know what the hell.....you can tell I was just exposed to this. Hospitals are reimbursed the percentage of the total cost over and above the current DRG Medicare payment .....hospitals will get that money for using your technology over some period of time which is sufficient to generate that, I forget what coverage decisions and to be made and DRG rates adjusted. If I could use you to try and explain this simply. The next thing gets worse for the reasons follow. If payment for noncapital income equals to 60% of added operating costs above 110% given the DRG rate i.e. 60% of the marginal cost above 110% of the DRG rate. You probably understand that, I don't. Incentives.....the hospitals are not reimbursed for the total cost of the.....the hospitals make its own investments ir technology. It's not

cost.....reimbursmeent, special marginal payments, terminate .....something like that. Maybe we could put that in writing and deliver it to you. Somebody else can explain it.

Q. You said defense is safer and health care is not--what do you attribute that to; our lack of.....lobbying.

A. Ronald Reagan as President. (laughter) And the fact that the American people are really concerned about national security. They have no reason yet to equate with anything other than spending money. You can get a copy of my book and will find a part of our problem there is the fact we have four forces, army, navy and unless there is some coersion from the top that says we're going to reform defense policy, it's not going to come from the Pentagon. If you saw Weinberger's letter that got released in the press, it said ah the Soviets are violating the therefore we got an excuse to spend more money. Plus you got tough economic times, a lot of states depending on defense contractors, and there's all kind of issues. The worse part of Reagan, the only thing I can say the President's doing, he's lost the opportunity to tell us how to use the defense system better.....

Q. Comment on your proposal for national council for access to health care and elaborate what you hope to accomplish from that legislation?

A. The for national council hopefully will be able to pass this year and that is to focus our attention on what happens when we eliminate the cost subsidies that were built into.....health care delivery. I think principally about hospitals. I would like to say while all the doctors were busy playing Teddy Kennedy on national health insurance the reality was we had national insurance--call the hospitals. Anybody who got sick had to go into a hospital, had to admit him, had to give him ..... then pay for it if they couldn't pay for it themsleves by charging the folks....government. So we hit the poor, the medical education, we hit various of those things in the price people pay for their care in much the same way we hit the price of rural telephone and electric service. Now we are in competition, possibly in competition with each other and the whole system is working this way, the insurance companies and health policies will also pay for what they get. They don't want to pay for medical education so we have to pay for that explicity and they won't pay for the poor anymore, we have to pay for that. All over the country, in the rural areas, as well as in some of our big cities, we have problems with access to health care. And we have access to preventive care and it is largely that issue that we would like to try and focus the national council on and to say there is still a problem to be dealt with here once we gain the efficiency in this deliver system we will still have some populations that don't have access because certian hospitals won't pay for them, doctors won't take them, services aren't available, nobody is paying. It's largely that that deals with eliminating cost subsidies. How are we going to

do that? I think what some hospitals hope what the commission will do is save all the hospitals in the country today .....Detroit and Chicago .....maybe we can save all these systems all over the country--that we can't do.

FOR IMMEDIATE RELEASE
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Contact: Karen Doyne
(202) 224-9475

The Year of the Leak
Classified Information and the News Media
Remarks by Senator Dave Durenberger
Chairman, Senate Select Committee on Intelligence
Chicago Council on Foreign Relations
Chicago, Illinois
April 4, 1986

The press has called 1985 the "Year of the Spy" and in many ways it was.

But, while recent headlines have been filled with names like Walker and Howard and Chin and Pelton, the nation's readers are also being bombarded with headlines like:

"U.S. discloses secret plan by the Sandinistas"

"CIA anti-Quaddafi plan backed"

"Secret U.S. missile aid reported"

These and dozens of other stories about sensitive matters involving intelligence and national security are based on deliberate leaks.

This kind of unauthorized disclosure of highly classified information -- especially the deliberate leaking of intelligence information that compromises sensitive sources and methods -- is sapping the strength of our national leaders. It is hurting our credibility with our allies. It is unnecessarily complicating relations with our adversaries. And, it is harming the morale and effectiveness of the dedicated men and women in our own intelligence agencies.

At a hearing of the Senate Intelligence Committee last fall on counter-intelligence and security problems, CIA Director Bill Casey stated that leaks "do more damage than anything else" to our intelligence capabilities and to "our reputation and reliability" in dealing with other nations.

I share Director Casey's concern. He is frustrated. The president is frustrated. And, our committee is deeply upset because the executive tends to lay blame on the elected members of the federal government and those individuals in the executive branch who oppose thorough congressional oversight of national security matters do so consistently.

A good many commentators and some government officials have criticized members of the Intelligence Committee for talking publicly about intelligence problems, even when we say nothing that is classified. And, of course, we've taken blame for the leaking of classified information, as well.

But, the facts are that there is probably nowhere else in Washington -- in the Congress or the administration -- where public officials are more concerned about protecting secrets and resisting the temptations to discuss classified matters in public than the Senate Select Committee on Intelligence.

Those who malign the committee for overt or covert release of classified information are, more often than not, seeking to destroy the credibility of the oversight process, rather than to improve security.

Every administration has faced the problem of leaks, but none so much as this one.

Some disclosures, of course, may be inadvertant. Recently, in reply to a question about aiding anti-communist rebels in Angola, the president said, and I quote, "We all believe that a covert operation would be more useful to us and have more chance of success right now than the overt proposal that has been made in the Congress."

The same thing occurred back in 1983, when the president first called publicly for Congress to support the "Freedom Fighters" in Nicaragua -- covertly. Some critics have charged that the phrase "Senate Intelligence" is an oxymoron; I would make the same assertion with respect to publicly-discussed "covert" aid.

So, what is the scope of the problem of leaking sensitive intelligence and national security information? How serious a situation are we really talking about?

Let me give you two quick examples:

In recent months, the press has reported alleged CIA covert action against Libyan Dictator Moammar Quaddafi. Whether true or false, such reports can lead to increased Libyan terrorism against Americans and U.S. interests.

And, of course, the recent moves by executive branch officials to release sensitive intelligence on Nicaraguan lobbying efforts on the contra aid issue were a classic example of ignoring the need to protect intelligence sources and methods.

A forceful press release from our committee gave the White House second thoughts about formally releasing the material. But, the Washington Times ran a leaked story on a "mole" in high Sandinista places and within two weeks three Nicaraguan officials were arrested and charged as CIA assets.

These two examples of dangerous leaks are only the latest in a long series of unauthorized disclosures that have jeopardized intelligence sources and methods.

During the SALT II debate in the late 1970s, leaks and disclosures about possible Soviet arms control violations, and our technical collection capabilities, gave the Soviets tremendous insight into our collection efforts, insight that can result in countermeasures to deny us vital strategic intelligence.

The same things happens when arms control compliance issues are leaked before the president can use the Standing Consultative Commission to attempt to find a solution through quiet diplomacy. On several occasions these issues have been leaked before or during SCC discussions making it that much harder for the Soviets to back down.

Since the Reagan Administration took office, and the Senate became Republican, overt use of top secret information on Soviet treaty compliance has increased substantially.

On November 6, 1985, for example, the Washington Post published a column by Rowland Evans and Robert Novak revealing what they claimed was a key finding in a national intelligence estimate on arms control monitoring. The article cited alleged difficulties in monitoring compliance. That disclosure clearly served the interest of one side in the debate within the administration over policy for arms control negotiations in preparation for the Reagan-Gorbachev summit. Their source clearly sought such advantage and was willing to use a calculated leak of sensitive intelligence information to obtain it. The frequency with which columns by these two writers are peppered with sensitive national security information has led to the rumor in Washington that the administration has two hot-lines -- one to the Kremlin and the other to Evans and Novak.

There are legitimate differences of opinion in this country about the wisdom of engaging in arms control negotiations with the Soviets; and verification of compliance with arms control treaties is at the heart of those differences. But, the overt use of leaks to discredit the verification process has no legitimate place in this crucial national debate.

Leaks are of particular concern in a crisis situation where the deployment of counter-terrorism rescue forces in disclosed. Such disclosures can doom a rescue effort before it gets off the ground. Network news directors have recently been pressed to withhold just his kind of information which they've obtained while the same information has been totally withheld from the Congress.

The cumulative impact of this misuse of leaks is to inhibit national leaders from taking measures that require secrecy for their success. That is a terrible and intolerable outcome. An unwillingness to take risks could prove fatal in a future crisis.

The most frequently mentioned "solution" to the leak problem, of course, is to shut down the flow of classified information to policymakers. The best reason for not plugging leaks in this manner, however, is that it will not work in the system we have today. Moreover, it is certainly not desirable. Failure to share information with the proper officials results in the loss of valuable advice and counsultation.

So the answer to leaks is not closing down the legitimate flow of information to policy makers. It is in doing something about the underlying attitudes that foster disrespect of the rules of secrecy.

The current ethos in Washington, of course, is just the opposite.

When the White House offers to release classified intelligence reports in order to sway votes in Congress, the lack of concern for sources and methods sends just the wrong message to subordinates in the administration: namely, "You, too, may play fast and loose with security."

When the executive branch officials then purport to discuss the intelligence sources themselves, we can only conclude that the message of laxity at the highest levels has been received by those further down.

What is needed today, throughout the government, is a new dedication to the ethic of silence by those entrusted with the most sensitive national secrets.

That ethic is not easily adhered to. It often requires sacrificing one's own ends or those of one's office or particular ideology, in order to serve larger national interests.

Frequently, the personal interest behind leaks lies in the protecting the position of one's own boss, or publicizing one's own opinions through the media. But, to use one's office and access to trusted national secrets in this manner is narcissism on the worst order.

Unfortunately, the news media must share at least part of the blame for this kind of prostitution of national secrets. Generally, the news media are all too willing to be used in return for information, particularly in the case of columnists who share a common ideology with those who are attempting to use classified information for their own selfish ends.

Also aggravating the problem is a woeful lack of knowledge on the part of some policymakers who regularly handle sensitive intelligence information.

Few senior officials appear to understand fully the damage that can result from disclosures of intelligence which does not appear sensitive on the surface, despite its high classification.

This inattention to the importance of maintaining security is not entirely the fault of officials who have not been fully briefed on the actual sensitivity of the information they get. Fortunately, in practice, the most sensitive information received by members of Congress in handled only by the Intelligence Committees, whose members have been fully briefed on why secrecy in necessary.

The fact that leakers are seldom caught and even less often punished -- regardless of the seriousness of the violation of trust -- also contributes to the problem. A security system based on the marginally deterrent effect of fruitless investigations is not likely to overcome the strong incentives that fuel the engines of bureaucratic conflict through the use of leaks.

Those who are at the greatest disadvantage in the leaking game are the critics outside of government.

In the debate over the president's strategic defense initiative, a physicist at Livermore, Ray Kidder, was quoted in the Los Angeles Times as saying: "The public is getting swindled by one side that has access to classified information and can say whatever it wants and not go to jail, whereas we -- we the skeptics -- can't say whatever we want. We would go to jail. That's the difference."

Another factor contributing to the growing problem of leaks is the large number of intelligence experts outside government -- many of whom are alumni of the intelligence community -- who comment to the press on "methods" even if, legally, they are barred from discussing "sources".

These individuals can carry with them important national security information and sometimes even a motive to engage in leaks -- without the threat of a supervisor or loss of employment hanging over them.

When the press is filled with public announcements of arrests, disclosures from executive branch sources, and comments by former intelligence officials, the congressional oversight committees are placed an an awkward and difficult position.

Because we are visible -- and because we are politicians -- it is often assumed that we are able and willing to provide confirmation or denial of information which has been leaked. A response of "no comment" simply makes oversight look passive and ineffective. In the long run, oversight committees with that kind of image can do little to help maintain broad support for legitimate intelligence programs.

If the executive branch would make some comment on the record in these situation, there would be no need for any further statement by the oversight committee.

The best procedure for handling problems caused by leaks is not to pretend they will go away, but to respond publicly. Nothing kills public attention quicker than satisfying the intense, but temporary, appetite for information.

Over the long haul, however, the single most important element in changing the environment for leaks is strong leadership that demonstrates, by example as well as rhetoric, a commitment to security.

Leaders who are willing to forego the game of one-upmanship -- and avoid the temptation to seek short-term personal gain at the expense of the larger national interest -- will take the first essential step toward stopping the use of leaks as an accepted political tactic.

Along with that kind of commitment, the administration and Congress must now look at specific adminstrative and legislative actions to enhance security for sensitive information.

As an initial step, the Senate Intelligence Committee is currently engaged in consultation with the NSC staff and other key officials in an attempt to reach agreement with the administration on an agenda for action to strengthen security for the most sensitive information. There are at least eight important items on that agenda.

The first item sure to be on our list is the need to educate policy makers on the damage caused by leaks.

Tailored security briefings by the intelligence community should be given to every new member of the White House and National Security Council staffs who handles intelligence information, as well as to political appointees in various agencies and to members of Congress and their staffs who have access to such information.

Secondly, in the context of the Intelligence Committee's larger agenda, we are also prepared to consider a proposal to deal with criminal penalties for leaks of highly classified information.

The committee's primary concern in considering the imposition of criminal penalties is the compromise of vital intelligence source and methods. But, at the same time, the law must provide room for public discussion of intelligence community failures. We should not withhold information which exposes failures or mistakes if that information does not endanger the continued effectiveness of the intelligence community or its vital sources and methods.

Third, any attempt to curb leaks must realize that the current classification and declassification process is at the heart of the problem.

I believe the time has come when the Congress and the executive branch must begin a serious dialogue on whether new legislation is necessary or desirable to protect the integrity of national secrets.

New legislation should be the last resort, however, after administrative measures are implemented. After all, the classification system is product of the executive branch. Information is labeled "confidential," "secret," or "top secret" -- and sometimes also placed in various special access compartments -- on the basis of standards set by the president in an executive order.

Even when Congress has legislated penalties for disclosure of specific categories of information, the executive branch of information, the executive branch determines how the information is classified and the procedures for authorized disclosure.

The only exception -- never used as yet -- is a provision in the resolution creating the Senate Intelligence Committee which prescribes a procedure for the full Senate to decide, in closed session, that classified information should be release over the president's objections.

One dimension of the classification problem is overclassification and unnecessary classification, which discredits the whole system and dissipates the resources available for the protection of truly sensitive secrets. Any effort to deter leaks must include a systematic attack on excessive classification.

The Senate Intelligence Committee's recommendations on information security state that recent espionage cases "have enlightened the security problems that result in large measure from attempting to protect too much and thereby stretching personnel and other security programs too thin." The last Justice Potter Stewart called this problem "secrecy for its own sake," in his opinion in the 1972 Pentagon Papers Case.

In its recommendations, the Intelligence Committee has recommended more extensive reform of the classification system than the executive branch has been willing to consider.

While the initiatives developed by the administration thus far are commendable and should be implemented at once, our committee proposes streamlining the system by adopting a simple, two-tier framework to replace the complicated and increasingly unworkable criteria now used to protect different types of information.

The committee has recommended that the prevalent approach to classification be reversed: Rather than assuming that information should be classified, the burden should be on showing the need for secrecy.

The committee's proposal would drop the "confidential" classification -- currently the lowest level assigned to secrets -- as recommended nearly thirty years ago by the Special Commission on Government Security.

At the second level of classification, the committee recommends special protective measures for a much smaller universe of data, based on a full analysis that assesses the risks.

And, the committee states that special protective measures should be imposed "only where necessary" and should not be "diluted by applying them too widely."

Streamlining the classification system should also make it possible to conduct independent audits of who has access to critical information, as a way to enforce the need-to-know principle.

Fourth, and even more important that the standards for classification, is the committee's recommendation that procedures be required for all authorized disclosures of legitimate secrets.

The Senate Intelligence Committee tries to follow two basic rules:

First, all media contact with staff are supposed to be forwarded to the committee press officer. And second, all statements by committee members or the committee spokesman should be fully on the record, so there is clear-cut accountability. We are also considering a more detailed code of conduct that may become part of the employment agreement signed be committee staff.

As far as we can tell, the executive branch does not have or enforce this kind of system. Yet, the practice of non-attributable background statements, often drawing on classified information, is pervasive.

Such statements are virtually indistinguishable from unauthorized leaks. They divert the overworked investigators of leaks from the cases in which administrative discipline, dismissal, or legal action is possible. And, they reinforce the climate of cynicism that leads to leaks and counterleaks.

Senior officials who authorize disclosures of classified information on background, without permitting attribution to the source, gain two advantages that undermine an effective information security system. First, they can conceal their responsibility for disclosure, just as the leaker does. Second, they can avoid giving the originating agency a chance to argue against disclosure and explain the harm it would do. If the same information disclosed "on background" were contained in a press release, it would have to be formally declassified.

In practice, however, classified information authorized for disclosure on background technically remains classified. There may well be valid reasons for retaining a "background" briefing classified character. But any serious effort to address the problem of leaks clearly must confront this practice and bring it under control

Therefore, the committee recommends that the president require, by executive order, that agreed procedures be followed whenever any official authorizes disclosure of classified information to the news media. The procedure should require either that the information be declassified or that a record be maintained for purposes of accountability when authority is exercised to disclose information that remains declassified. The procedures should also require consulting the agency that originate the information and should designate the officials permitted to exercise this authority.

Fifth, on the polygraph, we are considering whether the time has come for Congress to give the Defense Department a long-term statutory framework to implement a tightly-controlled program for

polygraph examinations of employees in the most sensitive positions. When this proposal first surfaced in 1983, the committee supported the concept of a trial program to ensure that the Defense Department program is limited to questions directly related to counter-intelligence concerns, such as contacts with foreign agents; and the procedures prohibit adverse actions based solely on polygraph charts.

Sixth, is to guarantee accountability of superiors for ensuring that employees continue to meet security standards after their initial clearance.

One of the lessons of recent espionage cases is that initial background investigations for security clearance do very little to detect a Walker or Whitworth who turns sour after assignment to a sensitive job.

Seventh, it is clear that personnel security cannot stop with the clearance. It must be a continuing process of monitoring cleared people to ensure that they remain reliable.

This sounds intrusive, but it need not be. The best supervisor knows his subordinate's problem, be they financial, psychological, or behavioral. When superiors fail to exercise this duty and the result is a serious compromise of classified information, they -- as well as the culprit -- must be held to account and penalized appropriately.

Eighth, and finally, is the need to address concerns about the tremendous variety in standards and procedures among departments and agencies.

In 1983, the president ordered the Justice Department to head an interagency group to bring some order out of this chaos. They worked for a year, them waited almost two years for policy guidance from the NSC. That effort has now resumed, with a mandate to develop uniform, government-wide minimum standards for security background investigations.

At the very least, there should be an office responsible to the president for policy oversight of the personnel security system. We have such an office for the classification system, and it has come up with valuable improvements.

The resistance to this idea from entrenched security bureaucracies will be tremendous, because everybody wants to keep control of their security "turf." Nevertheless, the protection of national secrets is too important to be left entirely in their hands.

What I have tried to lay out here today is the notion that the problem of leaks is real and it stands as a threat to national security just as serious as spying against our government by a foreign power.

There are a number of factors contributing to the growing use of leaks which must be recognized in dealing with this problem, the most important of which is a pervasive attitude in some quarters in Washington that allows the long-term national interest to be subjugated to the opportunity for short-term political gain.

Fortunately, there is now a recognition, both within the Congress and the administration, that we must jointly develop a comprehensive and coherent program to address the full range of counter-intelligence and security issues. That recognition is one of the more positive outcomes of the "Year of the Spy" and "The Year of the Leak."

Both the Congress and administration must improve its system of accountability, define responsibilities more clearly, and establish internal mechanisms to prevent both leaks and espionage. Our shared responsibility is to come up with constructive and realistic measures that will begin to create a new commitment to the protection of legitimate national secrets.

National security is too important to demand of ourselves anything less.

SPEECH TO

EMPLOYERS COUNCIL ON FLEXIBLE BENEFITS

BY DAVE DURENBERGER

FEBRUARY 28, 1985

I'D LIKE TO BE ABLE TO STAND HERE TODAY AND PAINT A ROSY FUTURE FOR EMPLOYEE BENEFITS. BUT THE FACT OF THE MATTER IS I CAN'T DO THAT, AND YOU WOULDN'T BELIEVE ME IF I TRIED TO.

THE TRUTH IS THE FEDERAL GOVERNMENT CAN'T AFFORD A ROBUST FUTURE FOR TAX FAVORED EMPLOYEE BENEFITS. YOU KNOW WHY; IT'S THE SLOWLY TICKING TIME BOMB--COMMONLY CALLED THE DEFICIT.

FOR SOME TIME NOW, AND PARTICULARLY SINCE THE PRESIDENT SENT UP HIS BUDGET MESSAGE, YOU AND THE AMERICAN PUBLIC HAVE BEEN GIVEN AN EDUCATION, BY THE MEDIA, ON THE FINANCES AND PROGRAMS OF THE NATIONAL GOVERNMENT.

BUT, IT'S A VERY DECEPTIVE EDUCATION, BECAUSE THE PRESIDENT'S BUDGET MESSAGE IS A VERY DECEPTIVE DOCUMENT. IT'S NOT LIKE THE ANNUAL REPORT OF A CORPORATION. IT'S MORE LIKE THE SEARS AND ROEBUCK CATALOGUE...A "WISH BOOK."

THE PRESIDENT WISHES, FOR EXAMPLE, THAT INTEREST RATES WERE LOWER. SO THE ECONOMIC PROJECTIONS FOR WHAT WE CALL THE "OUT YEARS" SHOW LOWER INTEREST RATES. AS LOW AS 5% ON THREE-MONTH TREASURY NOTES IN 1990.

NOW, FOR THOSE OF YOU WHO AREN'T INTO STOCKS AND BONDS...A 5% THREE MONTH TREASURY NOTE TRANSLATES INTO A 7-7 1/2% PERCENT HOME MORTGAGE. THAT'S WHAT THE PRESIDENT'S "WISH BOOK" IS BASED ON.

THE PRESIDENT ALSO WISHES THAT THE DEFICITS WEREN'T SO BIG. SO HE IMAGINES THAT THE LAWS OF THE LAND MANDATING SPENDING FOR THIS PURPOSE, OR THAT NEED, HAVE BEEN REPEALED AND THE SAVINGS REALIZED.

THE BUDGET WE RECEIVED MONDAY WISHES AWAY $239 BILLION IN SPENDING OBLIGATIONS IN THE NEXT THREE YEARS...$507 BILLION OVER FIVE YEARS.

Congress may will give the President all the savings he has asked for. But we have not passed the budget yet. And even a completely compliant Congress cannot conjure economic miracles. The deficit is not $180 billion. It will not be $144 billion in 1988. Those numbers are fictions. Wishes.

Shortly after the President's budget each year, we receive a second document. It gets less attention. It doesn't contain any wishes. "Just the facts, ma'am." The Congressional Budget Office outlook bases its 1986 projections on GNP growth averaging about 3.4% and interest rates at a flat 8.2% through 1990. Its revenue and outlay assumptions are based on current law.

Where are we really? The deficit for 1986 is not $180 billion, but $215 billion. And each year it grows. $239 billion. $249 billion. $272 billion. And, in 1990, $296 billion.

What does that mean? Well, it means that at the end of the decade the accumulated national debt will be $2.8 trillion. It was $800 billion in 1981. We will have added $2 trillion in a decade.

AND IT MEANS--ACCORDING TO CBO'S OUTLOOK--THAT INTEREST PAYMENTS ON THE NATIONAL DEBT WILL BE ABOUT $230 BILLION PER YEAR. IN 1981, INTEREST PAYMENTS WERE ABOUT $60 BILLION. IN TEN YEARS, WE WILL HAVE INCREASED DEBT SERVICE BY $170 BILLION. THAT IS THE CURRENT COST OF SOCIAL SECURITY. MORE THAN ENOUGH TO PAY THE SALARIES FOR ALL OF OUR SOLDIERS, SAILORS, AND AIRMEN--AND THEIR PENSIONS.

LISTEN TO THAT. WE'RE NOT TALKING ABOUT SADDLING YOUR KIDS WITH DEBT HERE. WE ARE TALKING ABOUT THINGS YOU WILL HAVE TO GIVE UP. IF WE DID NOT BORROW $2 TRILLION IN THE 1980s, THE SAVINGS IN ANNUAL INTEREST PAYMENTS BY THE END OF THE DECADE WOULD BE $170 BILLION PER YEAR.

THESE ARE SOBERING NUMBERS--NUMBERS THAT SAY WE ARE WAY OUT OF BALANCE--IN MORE WAYS THAN ONE.

IN FACT, RESTORING BALANCE IS ONE OF THE CENTRAL THEMES I'D LIKE TO SEE ADDRESSED BY ALL OF US--THE PRESIDENT AND CONGRESS--IN THE WEEKS AND MONTHS AHEAD.

--NOT JUST RESTORING BALANCE TO OUR FEDERAL BUDGET--ALTHOUGH THAT HAS TO BE OUR NUMBER ONE GOAL.

--BUT, ALSO RESTORING BALANCE WITHIN THE BUDGET--SO THAT ALL PROGRAMS--INCLUDING THE MILITARY AND SOCIAL SECURITY--MAKE THEIR FAIR SHARE CONTRIBUTION TO ELIMINATING THE DEFICIT.

--AND, ALSO, RESTORING BALANCE IN HOW WE TREAT GOVERNMENT SPENDING AND WHAT I LIKE TO CALL "TAX SPENDING." LET'S NOT FREEZE SPENDING ON FOOD STAMPS, IN OTHER WORDS, UNTIL WE ALSO FREEZE "TAX SPENDING" ON THREE MARTINI LUNCHES.

--AND, RESTORING BALANCE IN OUR ECONOMY--SO THAT FARMERS, AND THE BUSINESS OWNERS ON MAIN STREET, AND THE FOLKS ON THE IRON RANGE CAN SHARE IN THE ECONOMIC RECOVERY NOW UNDERWAY HERE, AND SO MANY OTHER PARTS OF THE COUNTRY.

--AND, FINALLY, RESTORING BALANCE TO OUR TAX SYSTEM--SO THAT IT IS FAIR AND EQUITABLE, AND SO THAT WORK AND SAVING AGAIN BECOME AS ATTRACTIVE AS CONSUMPTION AND SPENDING.

OF THESE, RESTORING THE BALANCE IN HOW WE TREAT GOVERNMENT SPENDING, AND "TAX SPENDING" IS WHAT I WOULD LIKE TO ADDRESS TODAY.

I'VE NOT SUPPORTED BUDGET FREEZES IN THE PAST. EVEN THE SO-CALLED ACROSS-THE-BOARD FREEZES. I'VE ALWAYS THOUGHT THAT SPENDING FREEZES ARE UNFAIR. BECAUSE IT REALLY ISN'T ACROSS-THE-BOARD AT ALL. IT ONLY FREEZES THOSE PEOPLE WHO GET THEIR GOVERNMENT SUBSIDY THROUGH SPENDING. IT DOESN'T GET TO THE AMERICANS WHOSE SUBSIDIES ARE HIDDEN IN THE TAX CODE.

FOR INSTANCE, IS IT FAIR TO FREEZE SPENDING ON FOOD STAMPS WHILE WE CONTINUE THE DEDUCTION FOR CORPORATE LUNCHES UNCHECKED? IS IT FAIR TO FREEZE MASS TRANSIT SUBSIDIES, WHILE THE NUMBER OF CORPORATIONS CLAIMING ACCELERATED DEPRECIATION FOR CORPORATE JETS AND LUXURY AUTOS CONTINUES TO CLIMB? WHAT ABOUT YOUR PC, THE NEWEST FRINGE BENEFIT? SHALL WE LET THAT LITTLE TAX EXPENDITURE BOOM, WHILE WE FREEZE THE EDUCATIONAL GRANTS FOR THE DISADVANTAGED? IS IT FAIR TO FREEZE HEALTH CARE FOR OUR VETERANS WHILE EMPLOYEES OF SOME MAJOR CORPORATION NEGOTIATE FOR A FIRST DOLLAR DENTAL PLAN AT TAXPAYER EXPENSE?

THE DOLLARS INVOLVED IN THESE TAX EXPENDITURES ARE NOT SMALL. THE JOINT COMMITTEE ON TAXATION COUNTS 106 ITEMS IN THE TAX CODE LIKE THE HOME MORTGAGE INTEREST DEDUCTION, THE DEDUCTION FOR STATE AND LOCAL TAXES, THE EXCLUSION OF EMPLOYER PROVIDED FRINGE BENEFITS, THE ENERGY CREDITS AND THE CAPITAL GAINS RATES.

IN 1984 THOSE TAX EXPENDITURES COST US $321 BILLION. IN OTHER WORDS, FEDERAL GOVERNMENT REVENUES WOULD HAVE BEEN LARGER BY $321 BILLION, IF WE DID NOT ALLOW THESE 106 CREDITS, DEDUCTIONS AND EXCLUSIONS. IN FISCAL YEAR 1985, THEY WILL COST $365 BILLION. AN INCREASE OF $44 BILLION IN ONE YEAR. THAT'S MORE THAN THE INCREASE THE PRESIDENT IS PROPOSING FOR DEFENSE. TAX EXPENDITURES WILL GO UP TO $404 BILLION IN 1986, ANOTHER $39 BILLION INCREASE. UP $83 BILLION IN TWO YEARS. THAT'S MORE THAN THE COST OF MEDICARE.

SO, IF OUR PROBLEM IS THE DEFICIT--THE GAP BETWEEN REVENUES AND SPENDING--I DON'T THINK IT IS FAIR TO SLAP A FREEZE ON ONE SIDE WHILE LEAVING THE SUBSIDIES TO GO UNCHECKED ON THE OTHERS.

CONSTRAINT IS NEEDED IN THE EMPLOYEE BENEFIT AREA. I WANT TO ASSURE YOU THOUGH, I DON'T USE THE TREASURY REFORM PROPOSAL'S DEFINITION OF CONSTRAINT! (SHOULD BE A CHUCKLE HERE--TREASURY PROPOSAL REPEALS ALL BUT HEALTH CARE.) I AGREE WITH SENATOR PACKWOOD THAT THERE IS AN OVERALL SOCIETAL GOOD ACCOMPLISHED BY USING "TAX SPENDING" TO ENCOURAGE THE PURCHASE OF EMPLOYEE BENEFITS. AND I AM ALL FOR FLEXIBILITY. ALLOWING THE EMPLOYEE TO CHOOSE HIS BENEFITS IS FUNDAMENTALLY FAIR. EMPLOYEES ARE INDIVIDUALS AND THEY HAVE INDIVIDUAL NEEDS THAT CAN BE BETTER MET WITH A FLEXIBLE BENEFIT PLAN.

AGAINST THIS BACKDROP OF CRUSHING DEFICITS THE PARAMETERS OF THE DEBATE ON EMPLOYEE BENEFITS HAVE BEEN SET. ON ONE HAND YOU HAVE THE TREASURY DEPARTMENT'S TAX REFORM PROPOSAL WHICH REPEALS STATUTORY BENEFITS EXCEPT MODIFIED RETIREMENT AND CAPPED HEALTH CARE BENEFITS. ON THE OTHER HAND IS THE CHAIRMAN OF THE FINANCE COMMITTEE, SENATOR PACKWOOD, WHO HAS VOCALLY SUPPORTED THE STATUS QUO.

I WILL SHORTLY INTRODUCE LEGISLATION THAT RECOGNIZES THE REALITIES OF OUR CURRENT ECONOMIC CONDITION, AND ADDRESSES THE CONCERNS OF BOTH ENDS OF THE EMPLOYEE BENEFIT SPECTRUM. THIS LEGISLATION WILL:

1) CONSTRAIN THE GROWTH OF EMPLOYEE BENEFITS EXCEPTING RETIREMENT BENEFITS.

2) RECOGNIZING THE IMPORTANCE OF PROVIDING INCENTIVES SO THAT THE PRIVATE SECTOR WILL MAKE AVAILABLE BENEFITS WHICH GOVERNMENT MAY OTHERWISE BE CALLED ON TO PROVIDE.

3) AID THE GOAL OF HEALTH CARE COST CONTAINMENT BY ENCOURAGING MOVEMENT TO ALTERNATIVES OTHER THAN FIRST DOLLAR COVERAGE.

4) INCREASE THE POTENTIAL FOR FLEXIBILITY BY ADDING MORE EMPLOYEE BENEFIT OPTIONS.

5) ADD EQUITY BY ALLOWING THE SELF-EMPLOYED, TO HAVE ACCESS TO THE EXCLUSION, TO THE SAME DEGREE AS EMPLOYEES.

6) FOSTER SIMPLICITY BY HAVING ONLY ONE NONDISCRIMINATION RULE APPLY.

It sounds too good to be true, yet I know that initial resistance to the idea may come from all sides. Thus, those employers who don't like it, or find it unworkable for their situation can continue to use current law.

Essentially then, the legislation will propose an alternative to current law. If the employer opted in, current law would not apply. All employee benefits, except retirement, dependent care and Section 132 benefits, would be capped. Benefits provided over the cap would be subject to tax. Employers could provide any benefits they desired including benefits currently taxable, and a taxable cash out would be allowed. This means complete flexibility; items could be offered such as group auto, extra life insurance, etc.

THE ADVANTAGES TO THIS APPROACH ARE NUMEROUS. THE CAP WILL CHECK THE GROWTH OF TAX FAVORED BENEFITS. THE GROWTH OF BENEFITS HAS BEEN EXPLOSIVE. THE U.S. CHAMBER ESTIMATES THAT BENEFITS HAVE GROWN 1,077 PERCENT SINCE 1951. THIS LEGISLATION ONLY CAPS A PORTION OF THE ITEMS CONSIDERED EMPLOYEE BENEFITS, BUT IT IS A STEP IN THE RIGHT DIRECTION. ALTHOUGH CAPPED, THE PROPOSAL PROVIDES ROOM FOR EMPLOYEE CHOICE IN SELECTING BENEFITS.

THIS CHOICE MEANS INCREASED EFFICIENCY. THE BENEFIT CONSUMER CAN SELECT AMONG ALTERNATIVES, AND THE DOLLAR AMOUNT OF HIS OR HER RESOURCES TO COMMIT TO IT, THE AMOUNT OF SERVICE CONSUMED AND A CHOICE OF PROVIDERS.

THE FLEXIBILITY INHERENT IN CHOICE ALLOWS THE CONSUMER TO TAILOR THE KIND OF BENEFITS PROVIDED AND THE AMOUNT PROVIDED TO INDIVIDUAL TASTE AND NEEDS. THE BUREAUCRACY CANNOT KNOW WHETHER AN EMPLOYEE WOULD CONSIDER HIMSELF BETTER OFF WITH A LITTLE LESS HEALTH CARE AND A LITTLE MORE LIFE INSURANCE. NOR DOES THE PATERNALISTIC EMPLOYER KNOW WHAT'S BEST FOR ALL HIS EMPLOYEES.

A COMPLETE REVAMPING OF OUR APPROACH TO FRINGE BENEFITS, SUCH AS JUST DESCRIBED, WILL TAKE TIME TO PERCULATE. IN THE MEANWHILE IT IS IMPORTANT TO BRING EQUITY TO OUR CURRENT ARRANGEMENT FOR SUBSIDIZING PRIVATE HEALTH INSURANCE COVERAGE.

LET ME ILLUSTRATE THE CURRENT INEQUITY. A WORKER AT CHRYSLER, WHATEVER HE OR SHE MAY EARN, ENJOYS HEALTH COVERAGE WHICH COSTS UPWARDS OF $6,000 PER YEAR. THIS WORKER RECEIVES THIS PREMIUM TAX FREE, HE GETS A COMPLETE EXCLUSION.

A SELF-EMPLOYED BREADWINNER WILL HAVE TO PAY BETWEEN $2,000 AND $2,500 A YEAR IN PREMIUMS TO PROVIDE HIS FAMILY WITH EVEN MODEST HEALTH COVERAGE. AT THE SAME TIME, THIS SELF-EMPLOYED BREADWINNER WILL ONLY GET TO DEDUCT THAT PORTION OF THE PREMIUM PAYMENT AND OTHER HEALTH EXPENSES WHICH EXCEED 5% OF HIS ADJUSTED GROSS INCOME. IN MANY CASES THIS MEANS HE WILL PAY TAXES ON ALL OR PART OF HIS PREMIUMS WHILE THE CHRYSLER WORKERS RECEIVED A $6,000 VALUE, FREE.

EMPLOYMENT STATUS IS NO REASON TO PROVIDE A TAX EXCLUSION TO ONE INDIVIDUAL AND NOT ANOTHER. IT SEEMS TO ME, SINCE WE HAVE DETERMINED IT IS GOOD PUBLIC POLICY TO ENCOURAGE PRIVATE HEALTH COVERAGE THROUGH TAX POLICY, THEN EVERYONE, REGARDLESS OF EMPLOYMENT STATUS, SHOULD BE ELIGIBLE FOR THE SAME TREATMENT BY THE IRS.

I JUST MENTIONED HOW I FEEL ABOUT THE EXCLUSION FOR HEALTH BENEFITS. I HAVE ALWAYS SUPPORTED THE TAX CAP ON HEALTH PREMIUMS. BECAUSE I BELIEVE THAT IT IS ESENTIAL WE DESIGN TAX POLICY WHICH PROMOTES GOOD HEALTH POLICY--THE "BUYING RIGHT" BY INDIVIDUALS OF COST-EFFECTIVE HEALTH PLANS WILL BE PROMOTED BY LIMITING THE SUBSIDY FOR HEALTH PREMIUMS.

And, as you have heard today, I now advocate a total cap concept for fringe benefits. But to bring some equity to our health tax policy and to remain consistent to this total cap concept, I plan to also introduce seperate legislation to provide a capped exclusion to these who are not now eligible for the exclusion through their employment. My proposal is to provide a ceiling, identical to my total cap proposal. This proposal would thus be compatible with the eventual move to a total cap.

In conclusion, I support the concept of flexibility in employee benefits, and I believe in the use of "tax spending" as an incentive for the private sector to provide for social good. Yet concerns about the debt we are incurring and the unchecked growth of health care costs compells that alternatives to the status quo be examined. I am convinced that my alternative is workable, and as the legislative process unfolds, I would appreciate your input, and hopefully, your support.

Thank you very much for the opportunity to be with you today.

REMARKS BY
SENATOR DAVE DURENBERGER
UNIVERSITY OF WISCONSIN
JUNE 9, 1985

When an obscure Polish astronomer named Copernicus argued that the earth revolves around the sun, he was jailed and his writings were suppressed.

For several thousand years, people had believed that the sun and all other planets revolve around the earth. This was, of course, a logical conclusion for people who simply looked at the rising and setting of the sun, and did not think in terms of celestial mechanics. And over time, what people thought of as obvious became wrapped up with religious and philosophical overtones.

For instance, many people argued that the sun and the planets revolved around the earth because the earth and its human residents were clearly the most important of God's creations, and it was therefore only fitting that they should be at the center of everything. The result of this kind of reasoning was that when Copernicus announced his discovery, he did more than baffle people; he offended them as well. It took another century or two before Copernicus was proved right.

It is time, I think, for something like the Copernican revolution in our approach to world affairs.

Since the late 1600s, most people have thought of the thing we call a nation-state as the fundamental element of world affairs. Since the early 1800s, people have thought in terms of balance among larger and smaller nation-states.

And for the last 45 years, people have become accustomed to thinking of the world almost exclusively in terms of two very large nation-states which we call super-powers. Like the people who thought it was "obvious" that the sun revolved around the earth, many people today think that all of world affairs revolves around the two super-powers.

And like those who invested their belief about the sun with religious overtones, there are some today who still believe that all world affairs revolve around the U.S. and the Soviet Union because that is what was intended to be.

These beliefs aren't found just on one end of the political spectrum. People on the left, for instance, will often argue that all the evils in the world--hunger, poverty, warfare, repression--are caused by the United States, and by such U.S. tools of foreign policy as the CIA or the foreign aid program. But people on the right will make the same kind of argument about the Soviet Union.

And people in the center, who think the world isn't such a bad place, will often credit their happiness to the basic era of political stability which has come about with the rise of the superpowers.

It's time for a new way of thinking.

I don't intend to argue that the super-powers are powerless, or that they don't have major responsibility for a lot of the ill and the good alike around the world. But I do think it's time we recognize that the world is a far more complex place than we used to think it is, and that some things are beyond the power of the largest nation to control, even if it wanted to. In fact, some things which we call "world affairs" are going on as though there were no such political organization as the nation-state at all.

There are two good examples of that reality presented by this conference today.

First, consider the fact that 20 percent of you in this room are citizens of other nations, and that the 80 percent of you from the United Staes come from 38 very separate states. In other words, you are a very diverse group. But you share some common outlooks and common interests, no matter where you come from. That's what has brought you together today.

Despite the fact that you were brought up in diverse political cultures, none of you has let your nationality so totally define your personality that you have nothing in common with someone else. Instead, your nationality is a part of who you are, but not the entire definition. You are meeting as people, not as Americans or Germans or Brazilians.

And, to top it off, you were brought together not by an organization of nation-states, such as the UN, but by an international service organization which reaches across national boundaries. So the nation-state doesn't have the power to define personality that it had 100 years ago, when conferences of this kind were comparatively rare.

But second, I ask you to think of the four topics you will be addressing today: the nuclear arms race; Central America; the Middle East; and the politics of global hunger.

If the world were defined simply by one of two nation-states--if everything revolved around the United States and the Soviet Union like we once thought everything revolved around the earth--these problems either would not exist at all, or their solution would be comparatively easy to diagnose.

But, as much as the super-powers have to do with each one of these urgent and complex problems, it simply inaccurate to say that they are defined by what in the jargon is called a "bipolar world"--a world divided simply into a Soviet camp and an American camp.

And as much as the super-powers might be able to do to help solve these problems if they truly set out to cooperate, it wouldn't be enough, for their power to do good is more limited than people think, just as their power to do evil is also more limited. For good or for ill, we don't run the world.

Consider first the nuclear weapons question. Now we all know very well that the U.S. and the Soviet Union between them have perhaps 30,000 or 40,000 nuclear weapons--an amount of destructive power which it is beyond our imagination to understand. And we all know very well that the arms race which builds these numbers up every day is terribly wasteful and terribly dangerous. So clearly, arms control is an issue which heavily involves the superpowers and the alliance systems that those super-powers have erected over the past four decades.

But is the U.S.-Soviet competition the only arms control worry we face? For that matter, is it necessarily the most dangerous? What about the prospect of nuclear proliferation--the spread of nuclear weapons to other nations which go to war every few years? Isn't the risk of a nuclear shot fired in anger even greater in the case of India and Pakistan, or Israel and Syria, or Iraq and Iran?

At least the Soviets and the Americans have pretty well come to understand that a war between them must never happen, because it will mean the end of both their countries. What about nations that stock only tens, instead of tens of thousands, of weapons? Might they not feel tempted to use them? And finally, what about the threat of nuclear terrorism by either a pariah nation like Libya or a non-nation like the Red Brigade or Turkish Grey Wolves? Aren't <u>these</u> major arms control problems?

The answer, of course, is that the arms control problem is not simply a matter of the arms race between the superpowers. In fact, without too much exaggeration, you might say that the super-powers are really quite powerless--thanks to nuclear weapons. For both of them understand that in today's world a Soviet or American threat to use nuclear weapons against the other nation is simply not going to be believed. But a threat by a smaller nation or a trans-national movement or a terrorist group may well be believed.

This doesn't mean we should ever slacken off in our attempt to control, reduce, and eliminate the superpower nuclear weapons stocks. We can't afford for one moment to be distracted from that vital goal. But it does mean that even if we were to accomplish total nuclear disarmament--or even if, somehow, there were no superpowers--the arms control problem would still be here, and it would still be scary. A bipolar world is not the total definition of the problem, and a bipolar solution is not going to be the end of the problem.

C

Next, think about Central America. A lot of Americans continue to argue that the poverty, repression , and violence of the region are all the consequence of Soviet meddling. A lot of other Americans believe that these problems came about solely because of the United States and a few multi-national corporations. Again, I wish the problem were that clear, for we would then know what to do. But it isn't.

There is not question that the United States record in Central American over the past 150 years has been pretty dismal. We invaded Nicaragua a number of times. and we set up the Somoza government. Major corporations set up under our protection took much and left little. But did this cause the Sandinista National Directorate to purge the refolution of every one of tis democratic revolutionaries and now to turn so harshly on the revolution's democratic sponsors in Costa Rica?

If the United States record were exclusively for the bad, how could we explain the amazing record of justice, democracy, and peace compiled by the Costa Ricans, who welcome among themselves thousands of American citizens and hundreds of American investors and businesses?

Turning the coin over, if the United States were as powerful as some people think, it is hard to believe that things would have gone as badly for us as they have in Central America. And it is hard to think that the people of Central American would express the reservations they have about our diplomatic initiatives.

If peace is going to come in short term, and democracy and prosperity in the longer term, the United States will have a big role to play. But it won't play the only role, or even a dominant role. As President Duarte has demonstrated in El Salvador, as Cardinal Obando y Bravo is demonstrating in Nicaragua, and as thousands of others demonstrate each day with their lives, Central America's problems must be resolved by Central Americans themselves. We must accept this ourselves.

Clearly we have a large role to play, both in terms of facilitating a peace and in terms of providing resources. But we haven't run events in that region in many years, and we won't today or tommorrow. We are important, even vitally important, but we are not totally omnipotent.

The same kind of perspective applies in the Middle East. Think of how often a small ally has successfully defied its large sponsor in that region. Think as well of the role played in Middle East politics by things which have nothing to do with nation-states and international politics at all--things like religion and family or clan ties. Has any nation-state really been able to do much to end Lebanon's agony? For that matter, is Lebanon these days a nation at all, or is it instead a place?

D

Finally, of course, it should be apparent these days that the super-powers are often quite powerless about global hunger. Clearly, rich nations can provide food for poor nations, and they must. Just as clearly, resources spent by the superpowers on the arms race would benefit millions of people if they were spent instead on things like irrigation, refrigeration, distribution, and all the other complex parts of modern agriculture. It is truly an indictment of the human race that when this nation produces far more than it can possibly eat, children die of starvation in Africa and Asia.

But again, ask what kind of power the super-powers have in this situation. We learn repeatedly, for instance, that some of the worst starvation in Ethiopia comes not because of a shortage of food supplies, but instead because a vicious government engaged in a civil war is refusing to send food to the distant provinces where it is most needed. All of the wealth and power of the United States cannot change the morals of few heartless people. In Ethiopia, the world is revolving around people few of us ever heard of living in an ancient town, and not around the United States or the Soviet Union.

So the message here should be clear. We face enormous challenges today, and we will face them for the foreseeable future. You are going to be looking at four of them this week--four of the most urgent, vital, and complex. But world affairs has long since gone past the point when the problems and the promises were found exclusively among the super-powers or even for that matter among those political organizations we call the nation-state.

Many of the problems involve groups, regions, philosophies, and technologies which cross national borders. Many others involve nation-states that are often referred to as "small" or "powerless" when in fact they are anthing but. Power is a very loose term, and it is getting looser--and harder to define--nearly every day. It depends on situations, and the world's perception of those situations. It depends on changes in technology which occur faster than we understand.

And, more and more, it depends on intangibles such as common cause, individual commitment and the strength of will. A few Iranians armed with tape cassettes and strong convictions proved that a few years ago. A few Afghans armed with elementary weapons are proving it today.

I don't want to be misunderstood on this point, however. I am <u>not</u> saying that the super-powers are truly powerless. They aren't. They have real, useable power, no matter whether you measure it in terms of armies or cultures or technologies or foodstocks. Our material and moral strengths are enormous.

And I am clearly not saying that we in this country or the Soviets in theirs can somehow conveniently duck the moral responsibilitiy for problems we have created, contributed to, or can potentially help to end. I am not suggesting that the United States sit back on the sidelines saying "sorry, it's not our fault or our concern." We have much to do, and we should do it. Our nation and the USSR were born in revolutions 140 years apart. The difference is this.

Our revolution has a foundation in relifious freedom and individual liberties whcih provide not only moral mortar for the constitutional foundation of the U.S. government, but a guarantee that we measure our national security by the commitments other nations make to fredom and liberty of the individuals within their boundaries. The theft of the 1917 revolution by the Bolsheviks left the USSR a much difficult world role.

So what I am saying is that the solutions to the problems in world affairs are going to be harder in some respects and easier in others to think about than we have traditionally found. They will be harder because in many cases the problems simply won't bear any real relationship to this thing called the nation-state. But they will be easier because the people of your generation, around the world, are far less likely than my generation to have your imaginations limited by the nation-state.

You were born into a world that few people my age could have imagined when we were leaving high school--a world of mass communications which we call a "global village;" a world of international economics which has made us interdependent; and a world of merging cultures which reminds us that we are all humans.

In other words, world affairs are increasingly becoming human affairs. The problems--and the solutions--will still involve the nation-state, and particularly the super-powers, but they will involve people themselves. As a politician, I remember fondly the days when we thought all things could be solved by governments. But as an American and a human, I am excited about the prospect of a day when new organizations and new ideas grow up to assist the nation-state in dealing with world affairs.

In conclusion, may I say it's been a privilege serving as your keynote speaker tonight at your ninth annual world affairs seminar. It's rewarding to note that such a worthwhile endeavor is held every year by my home state's friendly neighbor to the east. I'll be back in the Twin Cities later tonight and be more than ready, should anyone at the airport ask the question, "How exactly to I get to Whitewater, Wisconsin." Now I'll know what to say!

My appreciation to Dr. Charlie Cottle and the University for allowing me to spend some time--precious little time--here in your refreshing surroundings, compared to the marble corridors and fantasyland that is Capitol Hill.

F

Best of luck to all of you--you're already in a very select group by being a part of this seminar.

Thank you and good night.

G